

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law also requires that the death certificate be retained by the hospital or attending physician. The law also requires that the death certificate be retained by the hospital or attending physician. The law also requires that the death certificate be retained by the hospital or attending physician.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

8108

CERTIFICATE OF DEATH

08101

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) b. STATE <u>D.C.</u> b. COUNTY <u>Washington</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington</u>	
c. LENGTH OF STAY in lb <u>18 days</u>		d. STREET ADDRESS <u>3714 - Tanier St NW</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Suburban</u>		e. IS RESIDENCE ON A FARM? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
3. NAME OF DECEASED (Type or print) <u>Elizabeth Allen</u>		4. DATE OF DEATH <u>July 25 1961</u>	
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>May 17, 1875</u>	
9. AGE (In years last birthday) <u>86</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>none</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>none</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Pennsylvania U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John J. Helff</u>		14. MOTHER'S MAIDEN NAME <u>John B. Allen</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service)		16. SOCIAL SECURITY NO. <u>53901</u>	
17. INFORMANT <u>John B. Allen</u>		Address <u>53901</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) <u>420.0</u> DUE TO <u>Acute myocardial infarction</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO <u>Arteriosclerotic Heart Disease</u> (b) (c)		INTERVAL BETWEEN ONSET AND DEATH <u>19 days</u> <u>10 yrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Virus pneumonia</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>July 8, 1961</u> to <u>July 25, 1961</u> , that (I) (we) last saw the deceased alive on <u>July 25, 1961</u> , and that death occurred at <u>5:45</u> AM, from the causes and on the date stated above.			
22a. SIGNATURE <u>Stephen W. Deiter</u> M.D.		22b. DATE SIGNED <u>July 25, 1961</u>	
22c. PHYSICIAN'S NAME (Type) <u>Dr. Stephen W. Deiter</u>		22d. ADDRESS <u>6719 - Wilson Lane Bethesda, 14, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Buried</u>		23b. DATE THEREOF <u>7/27/61</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Rock Creek Cem.</u>		23d. LOCATION (City, town or county) (State) <u>Washington DC</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Cherry Chas. Funeral Home</u>		25a. RECORD IN REGISTRAR <u>5703 minor</u>	
25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kears</u>		DATE <u>8/1</u>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

8109

08102

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda c. LENGTH OF STAY IN TB 28 Days d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) The Clinical Center, Bethesda 14, Md.			2. USUAL RESIDENCE (Where deceased lived, If institutions: Residence before admission) a. STATE Virginia b. COUNTY Arlington c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Arlington d. STREET ADDRESS 5326 Yorktown Boulevard e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First Middle Last Lillian Louise Allen			4. DATE OF DEATH Month Day Year July 13, 19 61		
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH September 7, 1912		9. AGE (In years last birthday) 48 yrs.		IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (County & State, or foreign country) Maine	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Joseph Smith			
14. MOTHER'S MAIDEN NAME Bertha Russell		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO			
16. SOCIAL SECURITY NO. Unascertainable		17. INFORMANT The Medical Records The Clinical Center, Bethesda 14, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) Gastro Intestinal Hemorrhage and Hepatic Failure Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) metastatic disease to marrow and liver (c) Carcinoma of Breast PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 7 months 5 years.					
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)		21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from June 15, 19 61 to July 13, 19 61 that <input checked="" type="checkbox"/> (we) last saw the deceased alive on July 13, 19 61 , and that death occurred at 7:00PM , from the causes and on the date stated above.			
22a. SIGNATURE Marvin A. Kirschner M.D.		ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> 7/15/61		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) Marvin A. Kirschner, M.D.		22d. ADDRESS National Institutes Of Health The Clinical Center, Bethesda 14, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF 7/18/61		23c. NAME OF CEMETERY OR CREMATORY FIRST CONGREGATIONAL KITTERY POINT MAINE	
23d. LOCATION (City, town or county) (State)		24. FUNERAL DIRECTOR'S SIGNATURE W. W. Chambers Co. 1400 Chapin St. N.W. Wash. D.C.			
25a. REC'D BY REGISTRAR JUL 18 '61		25b. REGISTRAR'S SIGNATURE Charles S. Fenn			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 may be retained by the hospital or attending physician. Pages 3 and 4 may be retained by the funeral director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

8110

08103

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Hyattstown c. LENGTH OF STAY in 1b 31 Yrs. d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Hyattstown d. STREET ADDRESS e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First EDITH Middle BELLE Last ANDERSON		4. DATE OF DEATH Month July Day 13 Year 19 61	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12 Feb 1874
9. AGE (In years last birthday) 87 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House-work	11. BIRTHPLACE (County & State, or foreign country) Maryland
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Nathan Kinna	
14. MOTHER'S MAIDEN NAME Jane R. Pickens		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No	
16. SOCIAL SECURITY NO. None		17. INFORMANT Mrs. Frank Linthicum (Same as item #1)	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary thrombosis 422.1 DUE TO Arteriosclerotic cardiovascular disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH 4 days 15 years	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 10/1/13 to 7/1/61 , that (I) (we) last saw the deceased alive on 7/1/61 , and that death occurred at 11:05 A.M. from the causes and on the date stated above.			
22a. SIGNATURE J. P. Kerr		22b. DATE SIGNED 14 July 1961	
22c. PHYSICIAN'S NAME (Type) J. P. Kerr, M. D.		22d. ADDRESS Damascus, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 7-15-61	
23c. NAME OF CEMETERY OR CREMATORY Methodist Cemetery		23d. LOCATION (City, town or county) (State) Hyattstown, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE M. R. Etchison & Son, Frederick, Maryland		25a. REC'D BY REGISTRAR JUL 17 '61	
25b. REGISTRAR'S SIGNATURE Arthur S. Evans			

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TO DEF. MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the Medical Director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
BM 7/59

FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Urbey</u> c. LENGTH OF STAY IN b <u>11 days</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Monty Gen Hosp</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>N. Y.</u> b. COUNTY <u>69X-2</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>New York City</u> d. STREET ADDRESS <u>118 E. 91st St.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Ada Marie Allan</u> First Middle Last 5. SEX <u>Female</u> 6. COLOR OR RACE <u>White</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		4. DATE OF DEATH <u>July 20 1961</u> Month Day Year 9. AGE (in years last birthday) <u>86</u> yrs. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>school teacher</u> 13. FATHER'S NAME <u>Joseph Allan</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u> 11. BIRTHPLACE (State or foreign country) <u>New Jersey</u> 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> 16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT <u>Hosp Record</u> Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Broncho-pneumonia & emphysema</u> DUE TO <u>900.0</u> Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. (b) <u>Fracture of left hip</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>11 days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH. <input checked="" type="checkbox"/> 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Fell down stair steps</u> 20c. TIME OF INJURY Month, Day, Year <u>8:30 a.m. 7-9 1961</u> 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u> 20f. (City or town) <u>Brinklow</u> (County) <u>Monty</u> (State) <u>MD</u>			
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Frank J. Bhoschert</u> EXAMINER'S NAME (Type) <u>FRANK J. Bhoschert</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED <u>7-20-61</u> Address (Street, city, town, or county)	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial-Transit</u> 22b. DATE THEREOF <u>7/20/61</u>		22c. NAME OF CEMETERY OR CREMATORY <u>North Burial Ground</u> 22d. LOCATION (City, town, or country) (State) <u>Providence, Rhode Island</u>	
23. FUNERAL DIRECTOR <u>Warner E. Pumphrey, Inc. 8434 Georgia Avenue Silver Spring, Maryland</u>		24a. REC'D BY REGISTRAR <u>JUL 24 '61</u> 24b. REGISTRAR'S SIGNATURE <u>Arthur S. Harris</u>	



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RESEARCH INSTITUTE OF THE UNIVERSITY OF CALIFORNIA
1101 S. BOULEVARD
LOS ANGELES 40, CALIF.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

8112

08105

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Takoma Park c. LENGTH OF STAY IN 1b one day d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Washington Sanatorium + Hospital		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Montgomery c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring d. STREET ADDRESS 2021 Luzerne Ave e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Laura Rose Antrim		4. DATE OF DEATH Month Day Year July 17 1961	
5. SEX Female		6. COLOR OR RACE white	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH January 1, 1894	
9. AGE (In years last birthday) 67 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY OWN HOME	
11. BIRTHPLACE (County & State, or foreign country) Vermont		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME MR. FRANK BRADLEY		14. MOTHER'S MAIDEN NAME Josephine Pocket	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO		16. SOCIAL SECURITY NO. Hospital Record	
17. INFORMANT Hospital Record		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) myocardial failure 43311 DUE TO Conditions, if any, which gave rise to immediate cause (b) auricular fibrillation (a), stating the underlying cause last. (c) generalized arteriosclerosis	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) obesity		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 6-2-54 to 7/17/61 , that (I) (we) last saw the deceased alive on 7/16 1961 , and that death occurred at 004 M, from the causes and on the date stated above.			
22a. SIGNATURE Dr. Shoemaker M.D.		22b. DATE SIGNED 7/17/61	
22c. PHYSICIAN'S NAME (Type) Dr. Shoemaker		22d. ADDRESS 8005 Woodbury Dr. S. Silver Spring, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 7/20/61	
23c. NAME OF CEMETERY OR CREMATORY Arlington National Cemetery		23d. LOCATION (City, town or county) (State) Arlington, Virginia	
24. FUNERAL DIRECTOR'S SIGNATURE Warner E. Pumphrey, Inc.		25. REC'D BY REGISTRAR DATE JUL 20 '61	
25. REGISTRAR'S SIGNATURE Arthur S. Kraus		25. REGISTRAR'S SIGNATURE Arthur S. Kraus	

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There are two main
highways running north-south
from the city of
Tucson, Arizona. The
first is the old
route which is
now a federal road.
The second is the
new highway which
is a federal road.

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which is a federal
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is a federal road.
The second highway
is the new highway
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

8113

08106

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u> c. LENGTH OF STAY IN 1b <u>16 hours 45 min</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Washington Sanitarium</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>New Jersey</u> b. COUNTY <u>Bergen</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Edgewater</u> d. STREET ADDRESS <u>149 New Bridge Rd</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Olive May Atkinson</u>		4. DATE OF DEATH <u>7 21 1961</u>		5. SEX <u>F</u>	
6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>10-22-72</u>	
9. AGE (In years last birthday) <u>55</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Maryland (Montg)</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>George Marley</u>		14. MOTHER'S MAIDEN NAME <u>Mary Beall</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>Not Known</u>		17. INFORMANT <u>Hospital Chart Room</u>	
18. CAUSE OF DEATH [Enter on only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cerebral anoxia</u> Conditions, if any, which gave rise to immediate cause (b) <u>aspiration of gastric contents</u> (c) <u>gastrojejunal dilation + retention</u>					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I. (a) <u>several days</u> <u>possibly weeks</u>					
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 <u>7/20</u> 19 <u>61</u>					
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>					
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)					
20f. (City or town) (County) (State)					
21. I certify that (I) (this hospital) attended the deceased from <u>7/20</u> 19 <u>61</u> to <u>7/21</u> 19 <u>61</u> , that (I) (we) last saw the deceased alive on <u>7/20</u> 19 <u>61</u> , and that death occurred at <u>11 A.M.</u> from the causes and on the date stated above.					
22. SIGNATURE <u>Marvin Wadler</u> M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> DATE SIGNED <u>7/21/61</u>					
22c. PHYSICIAN'S NAME (Type) <u>MARVIN WADLER</u> 22d. ADDRESS <u>8218 WIS. AV. - BETHESDA, MD</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> 23b. DATE THEREOF <u>7-24-61</u> 23c. NAME OF CEMETERY OR CREMATORY <u>Oaklawn</u> 23d. LOCATION (City, town or county) (State) <u>Balto. Md.</u>					
24. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. J. Dickerson-Sore</u> ADDRESS <u>Balto. Md.</u> 25a. REC'D BY REGISTRAR <u>Arthur S. Kraus</u> 25b. REGISTRAR'S SIGNATURE					



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
13M 9/55

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874

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18											
Item 6 from Form 10-55-1-1 iwK											
WT. 166 1/2 3114											
Reg. Dist. No. 08107											
1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND					2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>						
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>			c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u> 48						
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban Hospital</u>					d. STREET ADDRESS <u>6805 FAIRFAX RD.</u>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>BABY</u> First <u>BOY</u> Middle <u>ARGERAKIS</u> Last					4. DATE OF DEATH <u>JULY 4</u> Month <u>4</u> Day <u>19</u> Year <u>61</u>						
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>7/4/61</u>		9. AGE (In years last birthday) yrs. <u>2</u> Min. <u>53</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>ALEX NICHOLAS ARGERAKIS</u>					14. MOTHER'S MAIDEN NAME <u>JACQUELINE PAYLLIS NORQUIST</u>						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO		17. INFORMANT <u>FATHER</u>		Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Abletasis</u> <u>762.5</u> DUE TO <u>Prematurity</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Premature Labor.</u> (c) <u>Premature Labor.</u>										INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour o m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>July 4, 1961</u> , to <u>July 4, 1961</u> , that I last saw the deceased alive on <u>July 4, 1961</u> , and that death occurred at <u>2:30 P.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Bethesda Md</u> DATE SIGNED <u>Michael J. Buckley M.D. 4630 Montgomery Ave</u>											
ACTUAL SIGNATURE <u>Michael J. Buckley M.D. 4630 Montgomery Ave</u> NAME (Type) <u>Bethesda Md</u>											
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>		22b. DATE THEREOF <u>7/8/61</u>		22c. NAME OF CEMETERY OR CREMATORY <u>SUBURBAN HOSPITAL</u>			22d. LOCATION (City, town, or county) (State) <u>OLD GEORGETOWN RD. - BETHESDA, MD.</u>				
23. FUNERAL DIRECTOR'S SIGNATURE <u>AMELIA CARTER</u> ADDRESS <u>SUBURBAN HOSPITAL, BETHESDA, MD.</u>				24a. REC'D BY REGISTRAR <u>JUL 21 '61</u>		24b. REGISTRAR'S SIGNATURE <u>Colman E. Kinn</u>					

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OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death. TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

8115

C8103

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u> c. LENGTH OF STAY IN 1b <u>31 days</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban Hospital</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u> d. STREET ADDRESS <u>Briggs Rd & Lutes Lane</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Jane</u> Middle <u>E</u> Last <u>Barnhart</u>		4. DATE OF DEATH Month <u>July</u> Day <u>11</u> Year <u>1961</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH <u>August 22, 1899</u>		9. AGE (In years last birthday) <u>61 yrs.</u>		10. IF UNDER 1 YEAR: Months <u>10</u> Days <u>29</u> Hours <u></u> Min. <u></u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>Samuel J. Argent</u>		14. MOTHER'S MAIDEN NAME <u>Sarah V. Wilkinson</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war and dates of service) <u>Retired Clerk U.S. Government</u>		16. SOCIAL SECURITY NO. <u></u>		17. INFORMANT (Husband) <u>Jesse A. Barnhart</u> Address <u>As above</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Adenocarcinoma of extra-hepatic duct with pulmonary metastases.</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>SS.I</u> DUE TO (b) <u></u> DUE TO (c) <u></u>		INTERVAL BETWEEN ONSET AND DEATH <u>unknown</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u></u>			
20c. TIME OF INJURY Month, Day, Year <u>19</u> Hour a.m. <u></u> p.m. <u></u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u></u>	
20f. (City or town) <u></u> (County) <u></u> (State) <u></u>		21. I certify that (I) (this hospital) attended the deceased from <u>April 3, 1938</u> to <u>July 11, 1961</u> that (I) (we) last saw the deceased alive on <u>July 11, 1961</u> and that death occurred at <u>3:04 P.M.</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>Katharine A. Chapman</u>		22b. DATE SIGNED <u>July 11, 1961</u>			
22c. PHYSICIAN'S NAME (Type) <u>Katharine A. Chapman</u>		22d. ADDRESS <u>3924 Baltimore Ave., Kensington, Maryland</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>XXXX</u>		23b. DATE THEREOF <u>JULY 14, 1961</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Rockville Cemetery</u>	
23d. LOCATION (City, town or county) <u>Rockville</u>		23e. (State) <u>Maryland</u>			
24. FUNERAL DIRECTOR'S SIGNATURE <u>Warner E. Pumphrey, Inc.</u>		24b. ADDRESS <u>8434 Georgia Ave., Silver Spring, Md.</u>		25a. REC'D BY REGISTRAR <u>JUL 13 '61</u>	
25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>					

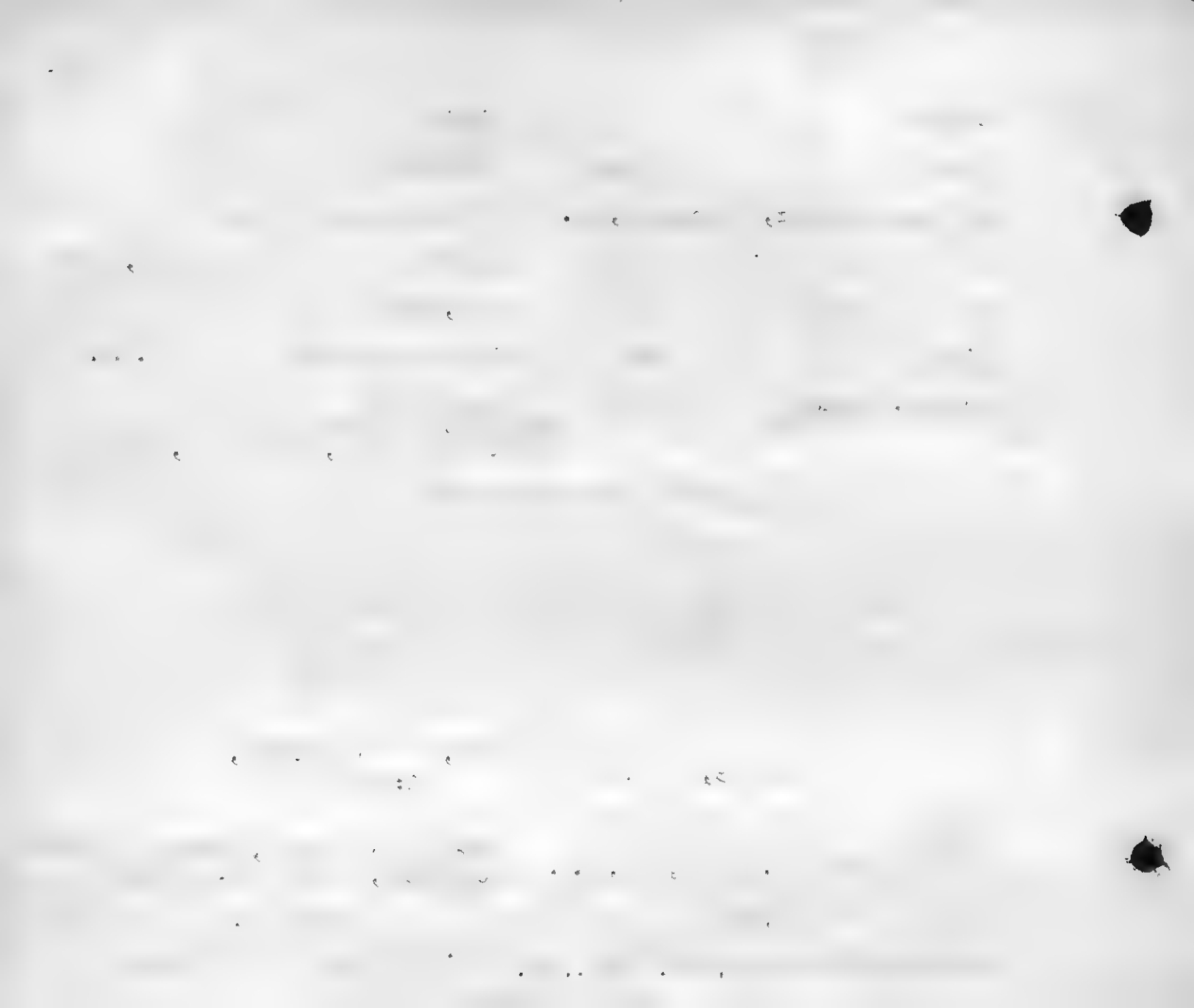
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

08109

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (if outside of corporate limits, write RURAL and give nearest town) Bethesda c. LENGTH OF STAY IN 1b 5 days d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) The Clinical Center, Bethesda 14, Md.		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Virginia b. COUNTY Alexandria c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) 337 West Groveton Street d. STREET ADDRESS 337 West Groveton Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Curtis Allen Bassler		4. DATE OF DEATH July 15, 1961		5. SEX Male	
6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH May 27, 1958	
9. AGE (In years last birthday) 3 yrs.		10. IF UNDER 1 YEAR Months 3 Days 15		11. IF UNDER 24 HRS. Hours 15 Min. 15	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Child		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (County & State or foreign country) District of Columbia	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Gerald R. Bassler		14. MOTHER'S MAIDEN NAME Nancy Allen	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) No		16. SOCIAL SECURITY NO. The Medical Record		17. THE DECEASED LIVED AT The Clinical Center, Bethesda 14, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) 2. 4. Acute lymphocytic leukemia DUE TO Conditions, if any, which gave rise to immediate cause (b) (c) 2. 4. Acute lymphocytic leukemia DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 1 year		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20. INTERVAL BETWEEN ONSET AND DEATH 1 year	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)		20c. TIME OF INJURY Hour 19 a.m. 19 p.m.	
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from July 10, 1961 to July 15, 1961 , that (I) (we) last saw the deceased alive on July 15, 1961 , and that death occurred at 2:00AM from the causes and on the date stated above.		22a. SIGNATURE Thorne S. Winter, III M.D.		22b. DATE SIGNED 7/15/61	
22c. PHYSICIAN'S NAME (Type) Thorne S. Winter, III, M.D.		22d. ADDRESS The Clinical Center, National Institutes of Health, Bethesda 14, Maryland		22e. REC'D BY REGISTRAR Jul 18 '61	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF July 17, 1961		23c. NAME OF CEMETERY OR CREMATORY Mount Comfort	
23d. LOCATION (City, town or county) Fairfax Co.		23e. STATE Virginia		23f. REGISTRAR'S SIGNATURE Jul 18 '61	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be retained by the hospital or attending physician. Pages 3 and 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

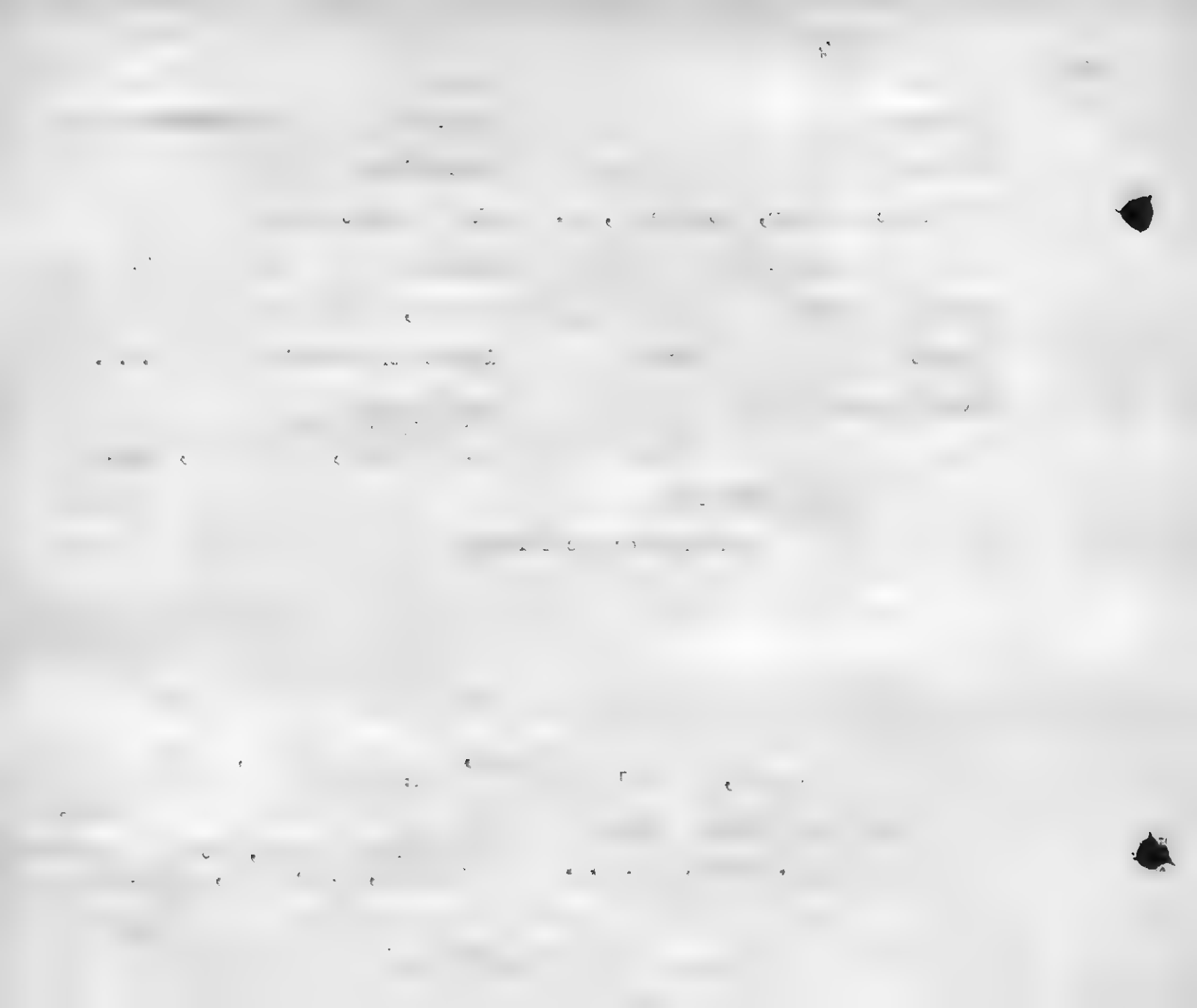
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

8117

08110

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (if out of corporate limits, write RURAL and give nearest town) Bethesda c. LENGTH OF STAY (in days) 35 days d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) The Clinical Center, Bethesda 14, Md.		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Montgomery c. CITY OR TOWN (if out of corporate limits, write RURAL and give nearest town) Hyattsville d. STREET ADDRESS 4100 Farragut Street		3. NAME OF DECEASED (Type or print) Kathleen Anne Behneman		4. DATE OF DEATH Month July Day 9 Year 1961															
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH February 27, 1946		9. AGE (in years last birthday) 15 yrs.		10. IF UNDER 1 YEAR Months 5 Days 1 Hours 1 Min. 1		11. IF UNDER 24 HRS. Hours 1 Min. 1									
10a. USUA. OCCUPATION (Give kind of work done during most of working life, even if retired) Student		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (County & State, or foreign country) District of Columbia		12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME George Behneman		14. MOTHER'S MAIDEN NAME Marion Berger		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) No		16. SOCIAL SECURITY NO. None		17. INFORMATION The Medical Record		18. ADDRESS The Clinical Center, Bethesda 14, Maryland			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Septicemia DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 2004-3 (b) Acute lymphocytic leukemia DUE TO (c)		19. INTERVAL BETWEEN ONSET AND DEATH 5 days 5 months		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year 19 Hour a.m. 1 p.m. 1		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) Bethesda		20g. (County) Montgomery		20h. (State) Md.	
21. I certify that (I) (this hospital) attended the deceased from June 4, 1961 to July 9, 1961 , that (I) (we) last saw the deceased alive on July 9, 1961 , and that death occurred 1:10AM from the causes and on the date stated above.		22a. SIGNATURE Thorne S. Winter, III		22b. DATE SIGNED 7/9/61		22c. PHYSICIAN'S NAME (Type) THORNE S. WINTER, III, M.D.		22d. ADDRESS The Clinical Center, National Institutes of Health, Bethesda 14, Maryland		23a. BURIAL, CREMATION, 23b. DATE THEREOF Burial 7/12/61		23c. NAME OF CEMETERY OR CREMATORY Arlington National		23d. LOCATION (City, town or county) Arlington, Virginia		23e. REC'D BY REGISTRAR Jul 13 '61		23f. REGISTRAR'S SIGNATURE Arthur S. Kline			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be retained by the hospital or attending physician. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
8118
CERTIFICATE OF DEATH

08111

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Bethesda c. LENGTH OF STAY IN 1b 94 Days d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) The Clinical Center		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE New York b. COUNTY New York c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) New York d. STREET ADDRESS 240 East 79th Street e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) MARJORIE THOMPSON BELLAWS First Middle Last		4. DATE OF DEATH July 13, 1961 Month Day Year	
5. SEX Female 6. COLOR OR RACE White 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> 8. DATE OF BIRTH October 17, 1905 9. AGE (In years) 55 yrs. IF UNDER 1 YEAR: Months Days Hours Min.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Statistician 11. BIRTHPLACE (County & State, or foreign country) Rhode Island 12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Daniel Bellows 14. MOTHER'S MAIDEN NAME Bessie A. Hood		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No 16. SOCIAL SECURITY NO. 100-26-3449 17. INFORMANT The Medical Record 100-26-3449 The Clinical Center, Bethesda 14, Maryland	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Reticulum Cell Sarcoma DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Possible Polyarteritis and/or Rheumatoid Arthritis		INTERVAL BETWEEN ONSET AND DEATH 5 months 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/> 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) _____		20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____ 20f. (City or town) (County) (State) _____	
21. I certify that (I) (this hospital) attended the deceased from April 10, 1961 to July 13, 1961 that (I) (we) last saw the deceased alive on July 13, 1961, and that death occurred at 7:10 a.m. from the causes and on the date stated above.			
22a. SIGNATURE Daniel V. Kimberg, M.D. 22c. PHYSICIAN'S NAME (Type) DANIEL V. KIMBERG, M.D.		22b. DATE SIGNED 7/13/61 ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> 22d. ADDRESS The Clinical Center, National Institutes of Health, Bethesda 14, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial-Trans 7/15/61 23b. DATE THEREOF 7/15/61 23c. NAME OF CEMETERY OR CREMATORY Graceland Cemetery 23d. LOCATION (City, town or county) Albany, New York 23e. REC'D BY REGISTRAR Jul 14 '61 23f. REGISTRAR'S SIGNATURE Carlton S. Haines		24. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey ADDRESS Bethesda, Maryland	



DATE **JUL 20 '61**

VR A15 (4)
15M 9/60



V5. A15ME
5M 9 60

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Items 18-21, Film G-4

08113

1. PLACE OF DEATH
a. COUNTY Montgomery MARYLAND

b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Takoma Park c. LENGTH OF STAY IN 1b D.O.A.

d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Wash. San. & Hosp. 716 Edelbert

3. NAME OF DECEASED (Type or print) Herbert Ellsworth Bergquist

5. SEX M 6. COLOR OR RACE W 7. MARRIED ☒ NEVER MARRIED ☐ 8. DATE OF BIRTH 3-17-11

9. AGE (In years last birthday) 50 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housing Mgmt 10b. KIND OF BUSINESS OR INDUSTRY GOVERNMENT 11. BIRTHPLACE (State or foreign country) Boston Mass 12. CITIZEN OF WHAT COUNTRY U.S.A.

13. FATHER'S NAME William A. Melkei Bergquist 14. MOTHER'S MAIDEN NAME Emma Mortenson

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes WW II 16. SOCIAL SECURITY NO. WW II 17. INFORMANT Mrs. Era M. Bergquist Address 716 Edelbert Drive Silver Spring, Maryland

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE Anaphylactic shock
927.0 DUE TO Bee sting
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I. e. 19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING CAUSE OF DEATH. ☐ 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) stung by bee while trimming shrubbery at home.

20c. TIME OF INJURY Month, Day, Year 7:20 p.m. 19 20 20d. INJURY OCCURRED While ☒ Not While ☐ at work ☐ 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home 20f. (City or town) (County) (State) Silver Spring, Montg. Md.

21. I certify that I took charge of the remains described above, held an Autopsy ☒. Inspection ☐. Inquiry ☐. and in my opinion death resulted from: Natural causes ☐. Accident ☒. Suicide ☐. Homicide ☐. Undetermined manner ☐.

ACTUAL SIGNATURE Frank J. Brosch CHIEF MEDICAL EXAMINER ☐ DATE SIGNED 7-17-61
EXAMINER'S NAME (Type) FRANK J. BROSCHE DEPUTY MEDICAL EXAMINER ☒
Address (Street, city, town, or county) 8434 Georgia Ave. Silver Spring, Maryland

22a. BURIAL, CREMATION, REMOVAL (Specify) Burial 22b. DATE THEREOF 7/19/61 22c. NAME OF CEMETERY OR CREMATORY Parklawn Cemetery 22d. LOCATION (City, town, or country) (State) Montgomery, Maryland

23. FUNERAL DIRECTOR Warner E. Humphrey Funeral Home 24a. REC'D BY REGISTRAR JUL 19 '61 24b. REGISTRAR'S SIGNATURE Arthur S. Thues

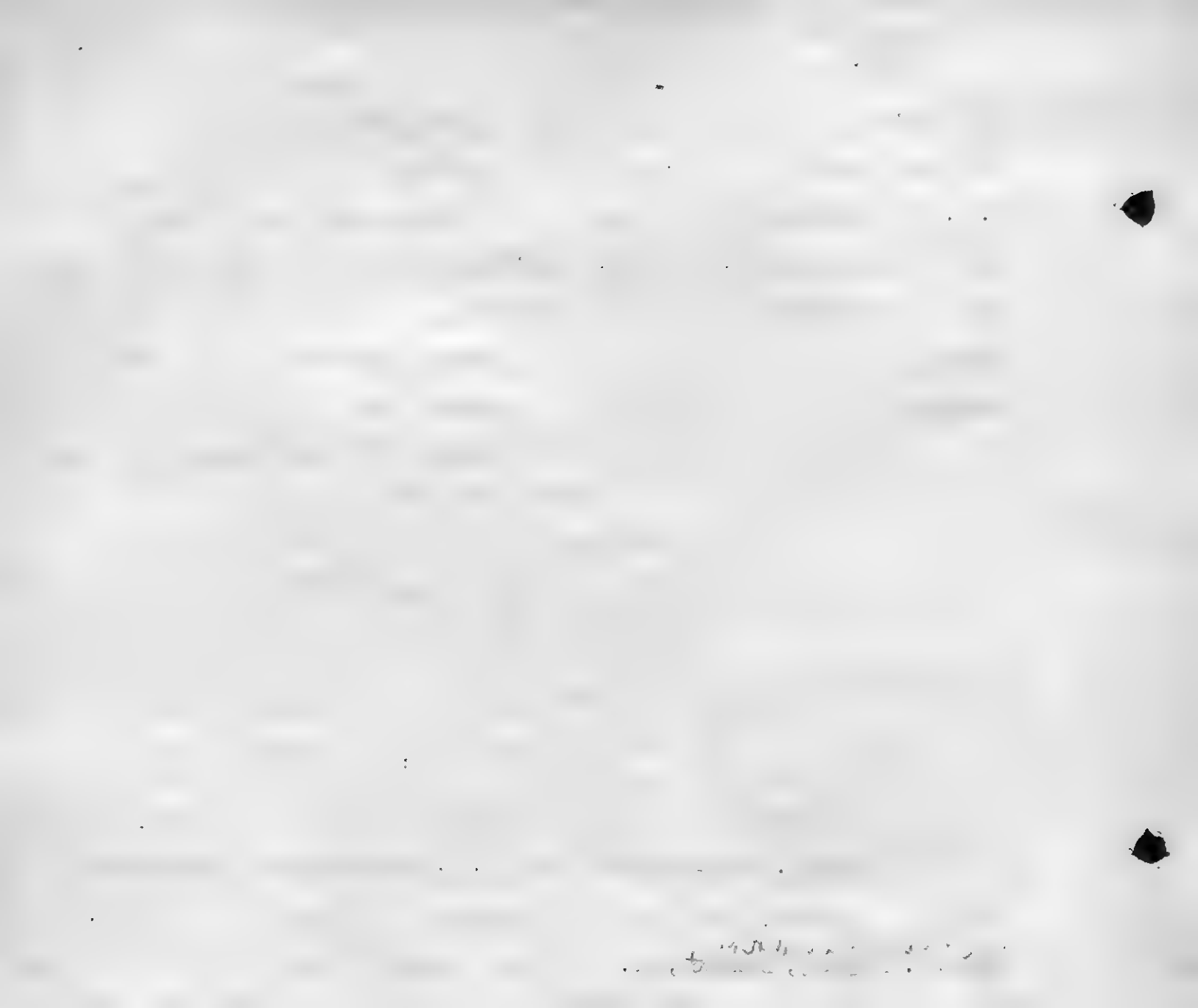
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be retained by the hospital or attending physician, and completely filled in by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR AIS (4)
ISM 9/60

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
8121
CERTIFICATE OF DEATH
08114

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Bethesda (Rural) c. LENGTH OF STAY IN b 4 days d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) U. S. Naval Hospital		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Washington b. COUNTY b. COUNTY c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Seattle d. STREET ADDRESS 1528 NE 89th St.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Sheridan Mark Berthiaume		4. DATE OF DEATH Month Day Year July 27 19 61			
5. SEX Male		6. COLOR OR RACE Caucasian		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH 4-8-87		9. AGE (in years last birthday) 74 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Education		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) Hurley, Wisconsin	
13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Nettie Hall		12. CITIZEN OF WHAT COUNTRY? USA	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO.		17. INFORMATION Address (W) Hildegard Berthiaume Same as # 2 above	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) Cardio - respiratory failure 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Intracerebral infarction and/or hemorrhage (c) Middle cerebral artery occlusion					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that (X) (this hospital) attended the deceased from July 23, 1961 to July 27, 1961, that (X) (we) last saw the deceased alive on July 27, 1961, and that death occurred at A.M., from the causes and on the date stated above.					
22a. SIGNATURE Joseph H. Eusterman		ATTENDING PHYS. <input type="checkbox"/> M.D. MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED July 27, 1961	
22c. PHYSICIAN'S NAME (Type) Joseph H. Eusterman, LT MC USN		22d. ADDRESS U. S. Naval Hospital, Bethesda, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Cremation		23b. DATE THEREOF July 28, 1961		23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Crematory	
24. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey		ADDRESS Robert A. Pumphrey, Bethesda, Md.		25a. REC'D BY REGISTRAR DATE JUL 31 '61	
				25b. REGISTRAR'S SIGNATURE Arthur S. Hous	



TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

1
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
8122
CERTIFICATE OF DEATH
08115

1 PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BETHESDA		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SUBURBAN HOSPITAL		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ROCKVILLE	
		d. STREET ADDRESS 1605 FORBES STREET	
		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First MARY Middle Clifton Last BEVARD		4. DATE OF DEATH Month July Day 31 Year 19 61	
5 SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH 9/22/81
9. AGE (In years lost birthday) 79 yes		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY -----	
11. BIRTHPLACE (State or foreign country) Nebraska		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Thomas L. Ewing		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 436-46-7865	
17. INFORMANT Robert L. Bevard - 1108 Prospect St. Elmhurst, Mich.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial infarction DUE TO Hypertensive + arteriosclerotic H.D. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) unknown DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 7 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from July 24, 1961 , to July 31, 1961 , that (I) (we) last saw the deceased alive on July 30, 1961 , and that death occurred at 8:45 AM , from the causes and on the date stated above.			
22a. SIGNATURE G. Bowditch Hunter, Jr. M.D.		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	
22c. PHYSICIAN'S NAME (Type) G. Bowditch Hunter, Jr.		22d. ADDRESS 809 Viers Mill Rd., Rockville, Md.	
22b. DATE SIGNED 7/31/61			
23a. BURIAL, CREMATION, REMOVAL (Specify) Bur-Transit 8/3/61		23b. DATE THEREOF	
23c. NAME OF CEMETERY OR CREMATORY Utica Cemetery		23d. LOCATION (City, town, or county) (State) Lincoln, Nebraska	
24. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey ADDRESS Bethesda, Maryland		25a. REC'D BY REGISTRAR AUG 4 '61	
		25b. REGISTRAR'S SIGNATURE Robert L. Hunter	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

1

8124

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

88117

I. PLACE OF DEATH
a. COUNTY Montgomery
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Takeoma Park
c. LENGTH OF STAY IN 1b 18 DAYS
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Washington Sanatorium & Hospital "Chart"

2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)
a. STATE Maryland b. COUNTY Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring
d. STREET ADDRESS 9211 Kingsburg Dr

3. NAME OF DECEASED (Type or print)
First Minnie Middle June Last BLACK

4. DATE OF DEATH Month July Day 12 Year 1961

5. SEX Female

6. COLOR OR RACE White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH 1902

9. AGE (In years last birthday) 59 yrs. IF UNDER 1 YEAR Months 5 Days 9 IF UNDER 24 HRS. Hours 1 Min. 0

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife

10b. KIND OF BUSINESS OR INDUSTRY LEESVILLE

11. BIRTHPLACE (County & State, or foreign country) LA

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME THOMAS S. FRANKLIN

14. MOTHER'S MAIDEN NAME SALLY E. WHITMAN

15. WAS DECEASED EVER IN U.S. ARMED FORCES? no

16. SOCIAL SECURITY NO NONE

17. INFORMANT Washington Sanatorium & Hospital "Chart"

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) BRAIN stem softening
(b) Ruptured intracranial aneurysm
(c) and surgical clipping intracranial artery

330X
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

INTERVAL BETWEEN ONSET AND DEATH 5-7 days
3 weeks
7 days

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year 19 **20d. INJURY OCCURRED** While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) **20f. (City or town)** (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 6/24 1961, **to** 7/13 1961, **that (I) (we) last saw the deceased alive on** 7/13 1961, **and that death occurred at** 11:00 A.M., **from the causes and on the date stated above.**

22a. SIGNATURE John T. Herd M.D. **22b. DATE SIGNED** 7/13/61

22c. PHYSICIAN'S NAME (Type) John T. Herd M.D.

22d. ADDRESS 1015 Spring St. Silver Spring, Md.

23a. BURIAL, CREMATION, 23b. DATE THEREOF Burial 7/15/61

23c. NAME OF CEMETERY OR CREMATORY Parklawn Cemetery

23d. LOCATION (City, town or county) (State) Montgomery Maryland

24. FUNERAL DIRECTOR'S SIGNATURE Warner E. Humphrey **ADDRESS** 8434 Georgia Avenue Silver Spring, Md.

25a. REC'D BY REGISTRAR JUL 17 '61 **25b. REGISTRAR'S SIGNATURE** Arthur S. Hines



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Payment may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 (M) I

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

8125

CERTIFICATE OF DEATH

08118

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If out of corporate limits, write RURAL and give nearest town) Bethesda c. LENGTH OF STAY IN 1b 87 days d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) The Clinical Center, Bethesda 14, Md.		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Somerset c. CITY OR TOWN (If out of corporate limits, write RURAL and give nearest town) Princess Anne d. STREET ADDRESS Mansion Avenue	
3. NAME OF DECEASED (Type or print) Dorothy Mary Bloodsworth		4. DATE OF DEATH Month July Day 29 Year 1961	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH September 5, 1908
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Insurance Agent		10b. KIND OF BUSINESS OR INDUSTRY Insurance	
11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY U.S.A.	
13. FATHER'S NAME Arch Henderson		14. MOTHER'S MAIDEN NAME Nora Dryden	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. Unascertainable	
17. INFORMANT The Medical Record		18. CAUSE OF DEATH (Enter on y one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) Hematoma in right frontoparietal region with severe cerebral compression PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Metastatic leiomyosarcoma, disseminated Pathologic fracture of right femur	
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH 2 days 6 months	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m. While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from May 3, 1961 to July 29, 1961 , that (I) (we) last saw the deceased alive on July 29, 1961 , and that death occurred at 10:50AM , from the causes and on the date stated above.			
22a. SIGNATURE John D. Heywood		22b. DATE SIGNED 7/30/61	
22c. PHYSICIAN'S NAME (Type) JOHN D. HEYWOOD, M.D.		22d. ADDRESS The Clinical Center, National Institutes of Health, Bethesda 14, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 8-2-61	
23c. NAME OF CEMETERY OR CREMATORY Manoken Presbyterian		23d. LOCATION (City, town or county) (State) Princess Anne, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Lee Funeral Home		24. ADDRESS Washington D.C.	
25a. REC'D BY REGISTRAR DATE AUG 2 '61		25b. REGISTRAR'S SIGNATURE Charles S. Hines	

9. 1937.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Payment may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

1

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

8125

08119

1. PLACE OF DEATH
a. COUNTY Montgomery
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Takoma Park
c. LENGTH OF STAY IN 1b 4 mos
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Washington Sanitarium + Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)
a. STATE Maryland
b. COUNTY Montgomery
c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Silver Spring
d. STREET ADDRESS 10809 Tenbrook Drive
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) Carmelo
4. DATE OF DEATH 7 5 1961
5. SEX Male
6. COLOR OR RACE White
7. MARRIED ☒ NEVER MARRIED ☐
WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH 5-5-48
9. AGE (In years last birthday) 63 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours M'n.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Barber
10b. KIND OF BUSINESS OR INDUSTRY Barber shop
11. BIRTHPLACE (County & State, or foreign country) Italy
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME Pleido Bonanno
14. MOTHER'S MAIDEN NAME Sarah Musumeci

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war and dates of service) no
16. SOCIAL SECURITY NO. 579-05-0459
17. INFORMANT Hosp. Records Address

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Respiratory Failure
DUE TO Circumstances of being + cerebral
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. helena
DUE TO (b) helena
DUE TO (c) helena

PART I. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) none

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒
INTERVAL BETWEEN ONSET AND DEATH 6 mos

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part I of item 18.) none

20c. TIME OF INJURY Month, Day, Year 7/4 61
Hour a.m. 7/4 p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) s/c
20f. (City or town) 68 7/5 (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 7/4 61 to 7/5 61, that (I) (we) last saw the deceased alive on 7/4 61, and that death occurred 10:00 AM from the causes and on the date stated above.

22a. SIGNATURE Harold F. ... M.D.
22b. DATE SIGNED 7/5 61
22c. PHYSICIAN'S NAME (Type) Harold F. ...
22d. ADDRESS 1352 UNIVERSITY BLVD
WHEELING, MD

23a. BURIAL, CREMATION, 23b. DATE THEREOF (Specify) BURIAL 7-8-1961
23c. NAME OF CEMETERY OR CREMATORY GATE OF HEAVEN
23d. LOCATION (City, town or county) WHEELING, MD. (State)

24. FUNERAL DIRECTOR'S SIGNATURE Heal Funeral Home 4812 La. Gr & W. ADDRESS
25a. REC'D BY REGISTRAR JUL 10 '61 DATE
25b. REGISTRAR'S SIGNATURE Arthur S. ...





TO HOSPITAL, OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be retained by the hospital or attending physician and complete in by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

8130

08123

1. PLACE OF DEATH a. COUNTY Montgomery		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE South Carolina b. COUNTY Columbia	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Columbia	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) The Clinical Center		d. STREET ADDRESS 5220 Fairfield Road	
3. NAME OF DECEASED (Type or print) NEIL		4. DATE OF DEATH July 13, 1961	
5. SEX Male		6. COLOR OR RACE White	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> (No middle name) BROOME		8. DATE OF BIRTH October 22, 1946	
9. AGE (In years, last birthday) 14 yrs.		10. IF UNDER 1 YEAR Months 14 Days 14 Hours 14 Min.	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Student		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Brooks A. Broome		14. MOTHER'S MAIDEN NAME Elizabeth Davis	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT The Medical Record		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Perforation of esophagus 204.3 DUE TO Candida infection Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last } DUE TO Acute Lymphatic leukemia	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that he (this hospital) attended the deceased from April 21, 1961 to July 13, 1961 that he (we) last saw the deceased alive on July 13, 1961 , and that death occurred at 12 Noon from the causes and on the date stated above.			
22a. SIGNATURE J. David Heywood		22b. DATE SIGNED 7/13/61	
22c. PHYSICIAN'S NAME (Type) J. David Heywood, M.D.		22d. ADDRESS The Clinical Center, National Institutes of Health, Bethesda 14, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial-transit 7-14-61		23b. DATE THEREOF 7-14-61	
23c. NAME OF CEMETERY OR CREMATORY Beulah Meth. Church Yard		23d. LOCATION (City, town or county) (State) Columbia, South Car.	
24. FUNERAL DIRECTOR'S SIGNATURE ROBERT A. PUMPHREY		25a. REC'D BY REGISTRAR JUL 18 '61	
ADDRESS Bethesda, Md.		25b. REGISTRAR'S SIGNATURE Charles E. Kneass	

1
 MARYLAND STATE DEPARTMENT OF HEALTH
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
 CERTIFICATE OF DEATH

8131

08124

1 PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived if institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>			
c. LENGTH OF STAY IN 1b <u>11 months</u>				d. STREET ADDRESS <u>7607 Takoma Ave</u>			
d. NAME OF HOSPITAL (If not in hospital give street address) OR INSTITUTION <u>Washington San. & Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3 NAME OF DECEASED (Type or print) First <u>David</u> Middle <u>William</u> Last <u>Brown</u>				4. DATE OF DEATH Month <u>July</u> Day <u>23</u> Year <u>1961</u>			
5 SEX <u>M.</u>		6. COLOR OR RACE <u>Cauc</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Aug. 20, 1960</u>	
9 AGE (In years last birthday) <u>11</u> yrs		IF UNDER 1 YEAR <u>11</u> Months <u>3</u> Days		IF UNDER 24 HRS <u>11</u> Hours <u>3</u> Min			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>—</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>							
13. FATHER'S NAME <u>James R. Brown</u>				14. MOTHER'S MAIDEN NAME <u>Elinor J. Gray</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>—</u>		17. INFORMANT <u>Washington San & Hospital</u> Address <u>—</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Congestive Heart Failure</u> <u>434.4</u> DUE TO (b) <u>Left Ventricular Dilatation and Hypertrophy</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u># 1 month</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART (a) <u>—</u>							
INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u>							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) <u>—</u>			
20c. TIME OF INJURY Month <u>Aug</u> Day <u>20</u> Year <u>1960</u> Hour <u>—</u> a m. <u>—</u> p m. <u>—</u>				20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>—</u>	
20f. (City or town) <u>—</u> (County) <u>—</u> (State) <u>—</u>							
21 I certify that (I) (this hospital) attended the deceased from <u>Aug 20</u> 19 <u>60</u> to <u>July 23</u> 19 <u>61</u> , that (I) (we) last saw the deceased alive on <u>July 23</u> 19 <u>61</u> , and that death occurred on <u>July 23</u> 19 <u>61</u> , from the causes and on the date stated above.							
22a. SIGNATURE <u>James M. Whitlock</u>				ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22b. DATE <u>7-23-61</u> SIGNED <u>—</u>	
22c. PHYSICIAN'S NAME (Type) <u>JAMES M. WHITLOCK</u>				22d. ADDRESS <u>7717 Carroll Ave Takoma Park Md.</u>			
23a. BURIAL, CREMATION, OR REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>July 26, 1961</u>		23c. NAME OF CEMETERY OR CREMATORY <u>St Mary's Cemetery</u>		23d. LOCATION (City, town, or county) <u>Cummary Md.</u> (State) <u>Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Arthur S. Walters</u>				ADDRESS <u>254 Carroll St. W.</u>		25a. REC'D BY REGISTRAR <u>JUL 25 '61</u> DATE <u>—</u>	
25b. REGISTRAR'S SIGNATURE <u>Arthur S. Walters</u>							



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

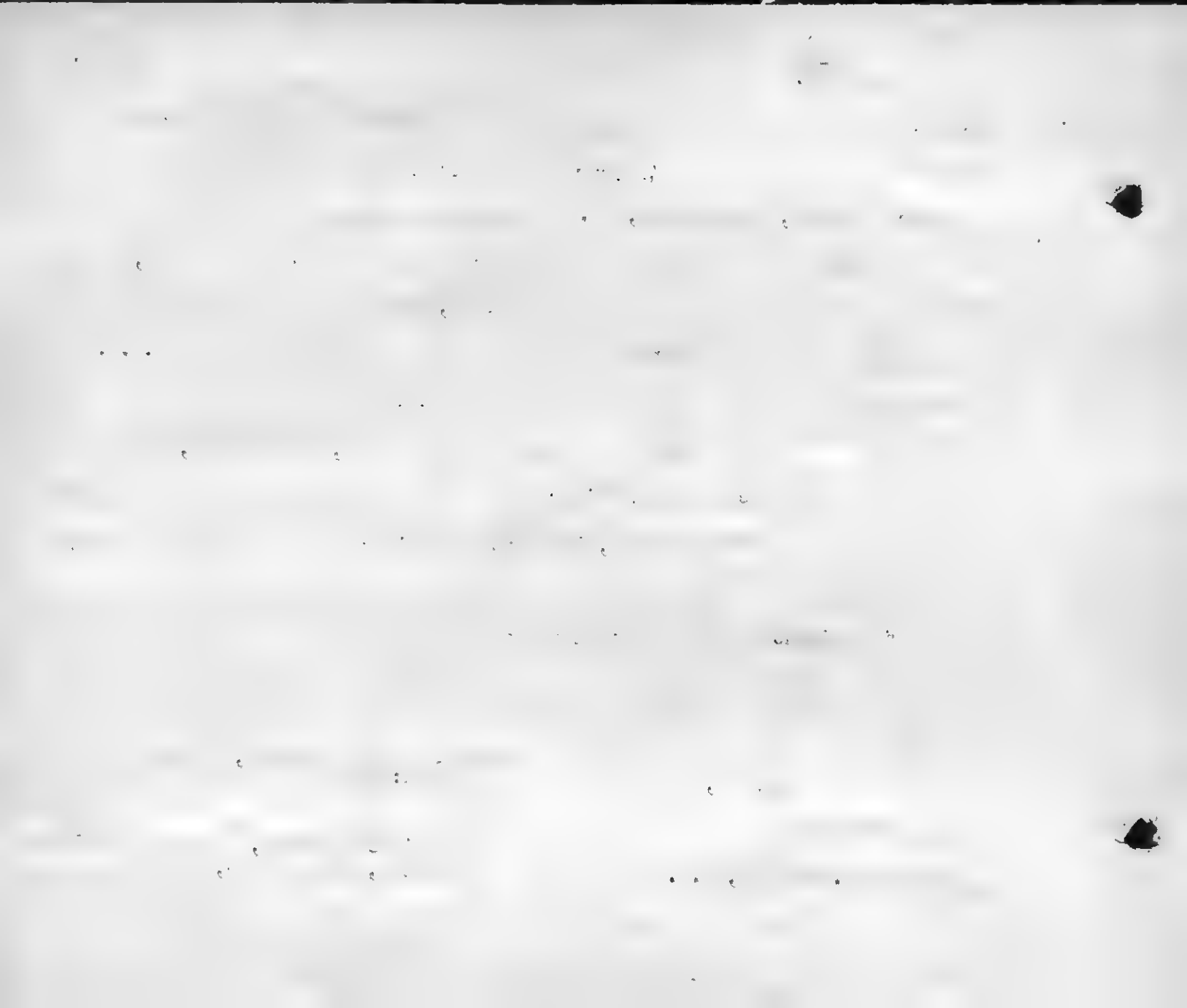
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

8132

08125

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Bethesda c. LENGTH OF STAY IN b 74 days d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) The Clinical Center, Bethesda 14, Md.		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Virginia b. COUNTY Fairfax c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Falls Church d. STREET ADDRESS 6413 Apex Circle	
NAME OF DECEASED (Type or print) Emily Mildred Brown		4. DATE OF DEATH July 8, 1961	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 13, 1902
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY None	9. AGE (In years last birthday) 59 yrs.
13. FATHER'S NAME Michael Neary		14. MOTHER'S MAIDEN NAME Mary Linnene	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) NO		16. SOCIAL SECURITY NO. None	
17. INFORMANT The Medical Records		18. CITIZEN OF WHAT COUNTRY? U.S.A.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute renal failure DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (c) Renal disease, type not determined DUE TO (b) Renal disease, type not determined DUE TO (c) Renal disease, type not determined		INTERVAL BETWEEN ONSET AND DEATH 6 weeks Unknown	
PART I. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 1) Portal cirrhosis 2) Atherosclerosis			
20c. TIME OF INJURY Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town)		20g. (County)	
20h. (State)		20i. (State)	
21. I certify that (I) (this hospital) attended the deceased from April 25, 1961 to July 8, 1961 , that (I) (we) last saw the deceased alive on April 8, 1961 , and that death occurred at 1:00PM from the causes and on the date stated above.			
22a. SIGNATURE Orlando W. McBride		22b. DATE SIGNED 7/8/61	
22c. PHYSICIAN'S NAME (Type) ORLANDO W. McBRIDE, M.D.		22d. WHERE SIGNED The Clinical Center, National Institutes of Health, Bethesda 14, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF	
23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town or county)	
23e. (State)		23f. (State)	
24. FUNERAL DIRECTOR'S SIGNATURE Robert J. Murphy		25a. REC'D BY REGISTRAR Jul 12 '61	
25b. REGISTRAR'S SIGNATURE Arthur L. Hume		25c. (State)	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

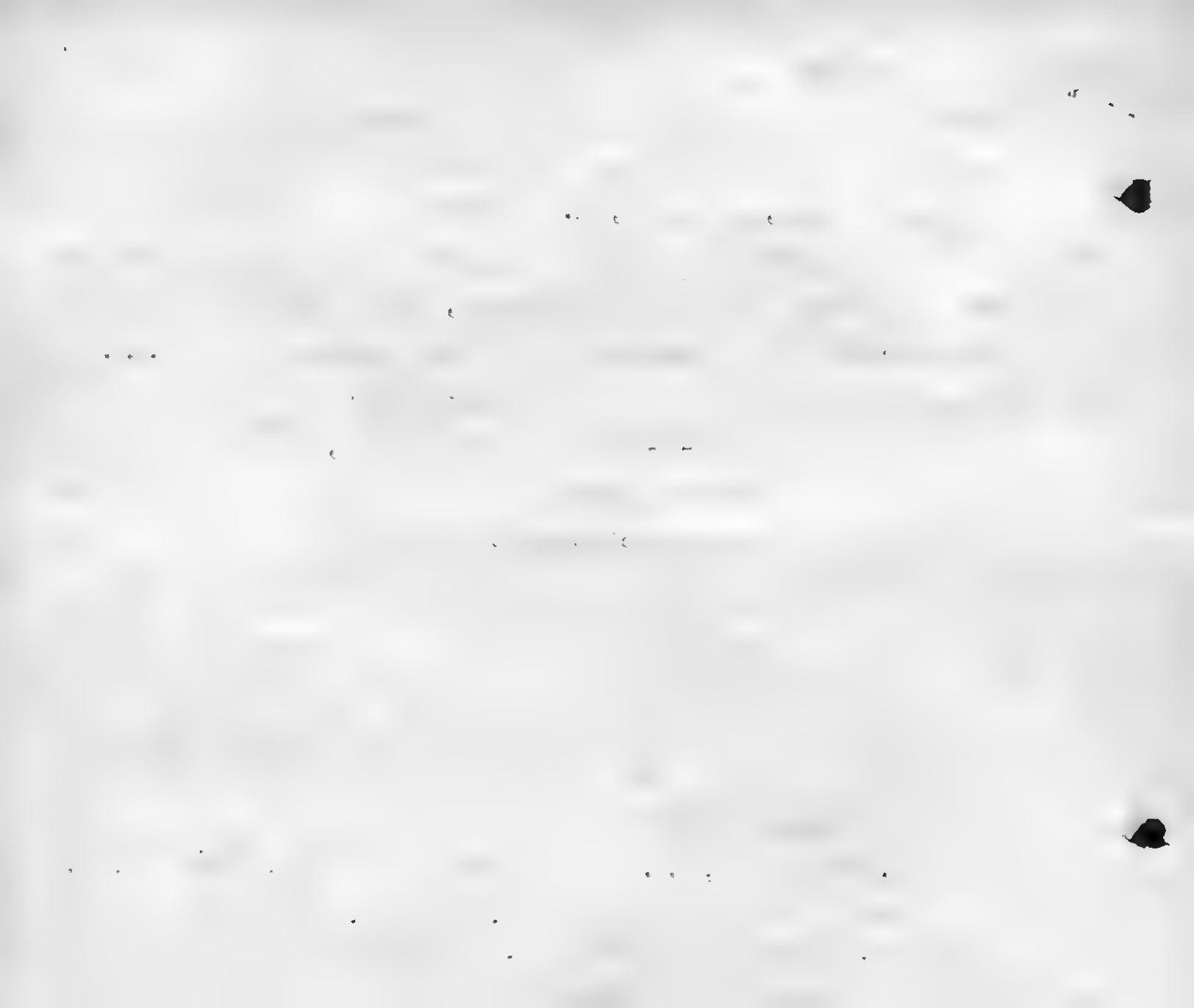
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

8133

08126

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Bethesda c. LENGTH OF STAY IN b. 20 days d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) The Clinical Center, Bethesda 14, Md.		2. USUAL RESIDENCE (Where deceased lived, if institutional Residence before admission) a. STATE South Carolina b. COUNTY Greenville c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Route # 4 d. STREET ADDRESS Route # 4		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Joshua Clyde Burgess		4. DATE OF DEATH July 29 19 61		5. SEX Male 6. COLOR OR RACE White 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH March 18, 1903 9. AGE (In years last birthday) 58 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Textile Worker 11. BIRTHPLACE (County & State, or foreign country) South Carolina 12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Hampton Burgess		14. MOTHER'S MAIDEN NAME Mattie Trotter		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) No 16. SOCIAL SECURITY NO. 248-05-3645 17. INFORMANT The Medical Record The Clinical Center, Bethesda 14, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial failure DUE TO (b) Acquired calcific aortic stenosis DUE TO (c) 48 hours Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 20d. INJURY OCCURRED While at work Not While at work 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)					
21. I certify that (I) (this hospital) attended the deceased from July 9, 1961 , to July 29, 1961 , that (I) (we) last saw the deceased alive on July 29, 1961 , and that death occurred at 2:00 AM from the causes and on the date stated above.					
22a. SIGNATURE W. Douglas Clark 22c. PHYSICIAN'S NAME (Type) W. DOUGLAS CLARK, M.D.		22b. DATE SIGNED 7/29/61 22d. ADDRESS The Clinical Center, National Institutes of Health, Bethesda 14, Md.		22e. REC'D BY REGISTRAR AUG 2 '61 22f. REGISTRAR'S SIGNATURE Arthur S. Thayer	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial-transit 7-30-61		23b. DATE THEREOF 7-30-61		23c. NAME OF CEMETERY OR CREMATORY Antioch Presby. Church Cem. Greer, South Carolina	
24. FUNERAL DIRECTOR'S SIGNATURE ROBERT A. PUMPHREY		ADDRESS Bethesda, Md.		25. REC'D BY REGISTRAR AUG 2 '61	



1
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. The pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

M

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O

2

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

0134

C8127

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) e. STATE <u>md</u> b. COUNTY <u>mntg</u>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Wheaton</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Wheaton</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>3502 Randolph Rd</u>		d. STREET ADDRESS <u>3502 Randolph Rd</u>	
3. NAME OF DECEASED (Type or print) <u>Herman Carl Burkhardt</u>		4. DATE OF DEATH <u>July 12 1961</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH <u>11-6-1913</u>
9. AGE (In years, last birthday) <u>47</u> yrs.		9. AGE (In years, last birthday) <u>47</u> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Manager</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Insurance Co.</u>	
11. BIRTHPLACE (State or foreign country) <u>N.Y.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.C.</u>	
13. FATHER'S NAME <u>Carl H. Burkhardt</u>		14. MOTHER'S M maiden NAME <u>Frieda Schneider</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>083-05-8794</u>	
17. INFORMANT <u>Arta Burkhardt (wife)</u>		Address <u>Stem 2</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1</u> DUE TO <u>Cornary occlusion</u> Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. } DUE TO (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) _____ 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day Year Hour e.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Frank J. Broschant</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>FRANK J. Broschant</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>7/15/61</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Parklawn Cemetery</u>		22d. LOCATION (City, town, or country) (State) <u>Montgomery Maryland</u>	
23. FUNERAL DIRECTOR <u>Warner E. Humphrey, Inc.</u>		24a. REC'D BY REGISTRAR <u>JUL 17 '61</u>	
24b. REGISTRAR'S SIGNATURE <u>Raymond A. Wisk</u>		24c. REGISTRAR'S SIGNATURE <u>7-12-61</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Part 1 may be retained by the hospital or attending physician, and completely filled in by the funeral director. Part 2 may be retained by the attending physician and completely filled in by the funeral director. Part 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
8135
CERTIFICATE OF DEATH

08128

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Seymour Nursing Home		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Montgomery c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) East Bexhill Drive, Kensington d. STREET ADDRESS 9705 E. Bexhill Drive e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Edith First Middle Last 4. DATE OF DEATH July 3 1961 Month Day Year		5. SEX Fe 6. COLOR OR RACE W 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH Nov. 8, 1877 9. AGE (In years last birthday) 83 yrs. IF UNDER 1 YEAR: Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife 10b. KIND OF BUSINESS OR INDUSTRY ----- 11. BIRTHPLACE (County & State, or foreign country) Michigan 12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Hubert Bunyea 14. MOTHER'S MAIDEN NAME Alma Bacon 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No 16. SOCIAL SECURITY NO. None 17. INFORMANT (D) Mrs. Seitz-same 2d Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Ventricular Fibrillation 433.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Chronic multiple arthritis, many years duration 20a. ACCIDENT WAS UNDERLYING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part I of item 18.)		INTERVAL BETWEEN ONSET AND DEATH 3 months 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)		21. I certify that (I) (this hospital) attended the deceased from Oct. 15, 1950 to July 3, 1961 , that (I) (we) last saw the deceased alive on June 27, 1961 , and that death occurred at 11:30 A.M. from the causes and on the date stated above. 22. SIGNATURE John N. Andrews 22c. PHYSICIAN'S NAME (Type) John N. Andrews 22d. ADDRESS 9601 Coleville Rd Silver Spring Md 22e. DATE SIGNED 7-3-61 22f. MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial 23b. DATE THEREOF 7/6/61 23c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln Cemetery 23d. LOCATION (City, town or county) (State) Prince Geo. Co., Maryland		24. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey ADDRESS Bethesda, Maryland 25a. REC'D BY REGISTRAR JUL 6 '61 25b. REGISTRAR'S SIGNATURE Arthur S. Hanks	

TO HOSPITAL BY ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR AIS (4)
ISM 9/59

8136

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

08129

1. PLACE OF DEATH a. COUNTY <u>Maryland</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> . COUNTY <u>Prince George</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Calverville</u>		c. LENGTH OF STAY IN 1b <u>16X-2</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Marilea Sanitarium</u>		d. STREET ADDRESS <u>102 Sharon Court</u>	
3. NAME OF DECEASED (Type or print) First <u>FRANK</u> Middle <u>Allen</u> Last <u>BUTLER</u>		4. DATE OF DEATH Month <u>7</u> Day <u>7</u> Year <u>1961</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>April 12 1888</u>
9. AGE (In years last birthday) <u>71</u> yrs		IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>factory foreman retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>retired</u>	
11. BIRTHPLACE (State or foreign country) <u>Halifax Nova Scotia</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>William Butler</u>		14. MOTHER'S MAIDEN NAME <u>Sarah Trenholm</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>C.H.7.</u>	
17. INFORMANT <u>Mr. Mary Butler</u>		Address <u>102 Sharon Ct</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>332X</u> DUE TO <u>Cerebral Thrombosis</u> Conditions if any which gave rise to immediate cause (a), stating the underlying cause (c) <u>Cerebral Arteriosclerosis</u> DUE TO (b) <u>Cerebral Thrombosis</u> (c) <u>Cerebral Arteriosclerosis</u>		INTERVAL BETWEEN ONSET AND DEATH <u>4 hrs</u> <u>72 hrs</u> <u>Indef.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>C.H.7.</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 <u>5/15/1961</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>5/15/1961</u> to <u>7/7/1961</u> , that (I) (we) last saw the deceased alive on <u>7/7/1961</u> , and that death occurred at <u>6:30 PM</u> , from the causes and on the date stated above.			
22a. SIGNATURE <u>Stephen H Jones</u>		22b. DATE SIGNED <u>7/8/61</u>	
22c. PHYSICIAN'S NAME (Type) <u>STEPHEN H JONES</u>		22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial July 11, 1961</u>		23b. DATE THEREOF <u>July 11, 1961</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Memorial Park</u>		23d. LOCATION (City, town, or county) (State) <u>Dorsey Md</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>De Witt Donaldson</u>		25a. REC'D BY REGISTRAR <u>JUL 13 '61</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles E. Hume</u>			

1 FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. Fill pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08130

Item 7 Film G292 8/18/61

1. PLACE OF DEATH
a. COUNTY Montgomery MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Pierce
c. LENGTH OF STAY IN 1b DOT
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 108 N. Frederick Ave

2. USUAL RESIDENCE (Where deceased lived, if institution, residence before admission)
e. STATE Fla. b. COUNTY Monty
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Pierce
d. STREET ADDRESS 711 N. 19th Street
e. 15. RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) Jennie Butler
4. DATE OF DEATH July 17 1961
5. SEX Female 6. COLOR OR RACE White 7. MARRIED ☐ NEVER MARRIED ☐ 8. DATE OF BIRTH 2/22/1904 9. AGE (In years, last birthday, Months, Days, Hours, Min.) 57 yrs. 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) septicemic 11. BIRTHPLACE (State or foreign country) Sumter S.C. 12. CITIZEN OF WHAT COUNTRY? U.S.C.

13. FATHER'S NAME James Sumter 14. MOTHER'S MAIDEN NAME Nancy Evans
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No 16. SOCIAL SECURITY NO. 111-11-1111 17. INFORMANT Mr. Ole Pierce (Sister) Address St. Pierre Florida

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
(IMMEDIATE CAUSE) (a) Coronary occlusion
DUE TO (b) _____
Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last, (c) _____
DUE TO (c) _____
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I. (a) _____

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH. 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) _____
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 20d. INJURY OCCURRED While at work ☐ Not While at work ☐ 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____ 20f. (City or town) _____ (County) _____ (State) _____

21. I certify that I took charge of the remains described above, held an Autopsy ☐ Inspection ☒ Inquiry ☒ and in my opinion death resulted from. Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☐ DEPUTY MEDICAL EXAMINER ☒ DATE SIGNED 7-17-61

ACTUAL SIGNATURE Frank J. Broschant EXAMINER'S NAME (Type) FRANK J. Broschant Address (Street, city, town, or county) _____
22a. BURIAL, CREMATION, REMOVAL (Specify) Shipped 22b. DATE THEREOF 7/20/61 22c. NAME OF CEMETERY OR CREMATORY Stone Brothers Funeral Home, Ft. Pierce, Florida. 22d. LOCATION (City, town, or country) _____ (State) _____

23. FUNERAL DIRECTOR Robert L. Snowden ADDRESS Rockville, Md. 24a. REC'D BY REGISTRAR JUL 24 '61 24b. REGISTRAR'S SIGNATURE Arthur L. Hume

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 may be retained by the hospital or attending physician, and completely filled in by the funeral director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

8138

08131

1. PLACE OF DEATH a. COUNTY MONTGOMERY b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING-WHEATON 9 days c. LENGTH OF STAY IN 1b 9 days d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Wheaton Nursing Home		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE MD. b. COUNTY MONTGOMERY c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING d. STREET ADDRESS 8606 - 2nd AVENUE		a. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) HONORA		4. DATE OF DEATH Month 7 Day 6 Year 1961		5. SEX FEMALE	
6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 1-8-86	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY		9. AGE (In years last birthday) 75 yrs.	
11. BIRTHPLACE (County & State, or foreign country) LONDON, ENGLAND		12. CITIZEN OF WHAT COUNTRY? AMERICAN		IF UNDER 1 YEAR: Months 7 Days 6 Hours 19 Mln. 61	
13. FATHER'S NAME EDWARD DOLLY MORE		14. MOTHER'S MAIDEN NAME KATHLEEN CLAMSON		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO	
16. SOCIAL SECURITY NO.		17. INFORMANT MARTIN CAHILL		Address SILVER SPRING, MD.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hypertensive Heart Disease DUE TO (b) Generalized Arteriosclerosis DUE TO (c) 15 yrs. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Bronchial asthma 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Hour a.m. Month, Day, Year 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)		21. I certify that (I) (this hospital) attended the deceased from Mar 1, 1946 to July 6, 1961 , that (I) (we) last saw the deceased alive on July 5, 1961 , and that death occurred at 2:30 PM on the causes and on the date stated above.		22a. SIGNATURE Francis P. Hannan M.D.	
22b. DATE SIGNED 7/6/61		22c. PHYSICIAN'S NAME (Type or print) FRANCIS P. HANNAN, MD		22d. ADDRESS 1511-17 ST. N.W. WASH. D.C.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 6-8-61		23c. NAME OF CEMETERY OR CREMATORY Not identified	
23d. LOCATION (City, town or county) (State) Washington, D.C.		24. FUNERAL DIRECTOR'S SIGNATURE Francis J. Hall		25a. RECORD BY REGISTRAR JUL 7 1961	
25b. REGISTRAR'S SIGNATURE Arthur S. Kears		25c. ADDRESS West, etc.		25d. DATE JUL 7 1961	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 may be retained by the hospital or attending physician. Page 3 should be detached for use as the burial-transit permit. If en please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

08132

8139

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural) c. LENGTH OF STAY IN IS 60 days d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) U. S. Naval Hospital		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Montgomery c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring d. STREET ADDRESS 10411 Hayes Ave. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) John Houston First Middle Last 4. DATE OF DEATH July 15 1961 Month Day Year		5. SEX Male 6. COLOR OR RACE Caucasian 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Lineman 13. FATHER'S NAME William H. CARNES		11. BIRTHPLACE County & State or foreign country Virginia 12. CITIZEN OF WHAT COUNTRY? USA	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO 229-22-7957 17. INFORMANT (D) Mrs. R.O. Wetmore, same as #2 above	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Encephalopathy due to Arterio-sclerosis with pseudobulbar palsy Conditions, if any, which gave rise to immediate cause (b) Diabetes mellitus & Hypertensive Cardiovascular Disease (a), stating the underlying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Diabetes mellitus & Hypertensive Cardiovascular Disease		INTERVAL BETWEEN ONSET AND DEATH 2 mos	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) U. S. Naval Hospital, Bethesda, Md.		20f. (City or town) (County) (State)	
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from May 16 1961 to July 15 1961 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on July 15 1961 , and that death occurred at 5:14 PM from the causes and on the date stated above.		22a. SIGNATURE G. J. Mc Mahon M.D. 22b. DATE SIGNED 7-15-61	
22c. PHYSICIAN'S NAME (Type) G. J. MC MAHON, LT, MC, USN		22d. ADDRESS U. S. Naval Hospital, Bethesda, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial-Shipment		23b. DATE THEREOF 17 July 1961	
23c. NAME OF CEMETERY OR CREMATORY Forest Lawn Cemetery		23d. LOCATION (City, town or county) (State) Norfolk, Va.	
24. GENERAL DIRECTOR'S SIGNATURE R. A. PUMPHREY ADDRESS 7557 Wisconsin Ave. Bethesda, Md.		25a. REC'D BY REGISTRAR JUL 19 61 25b. REGISTRAR'S SIGNATURE Arthur S. Fries	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

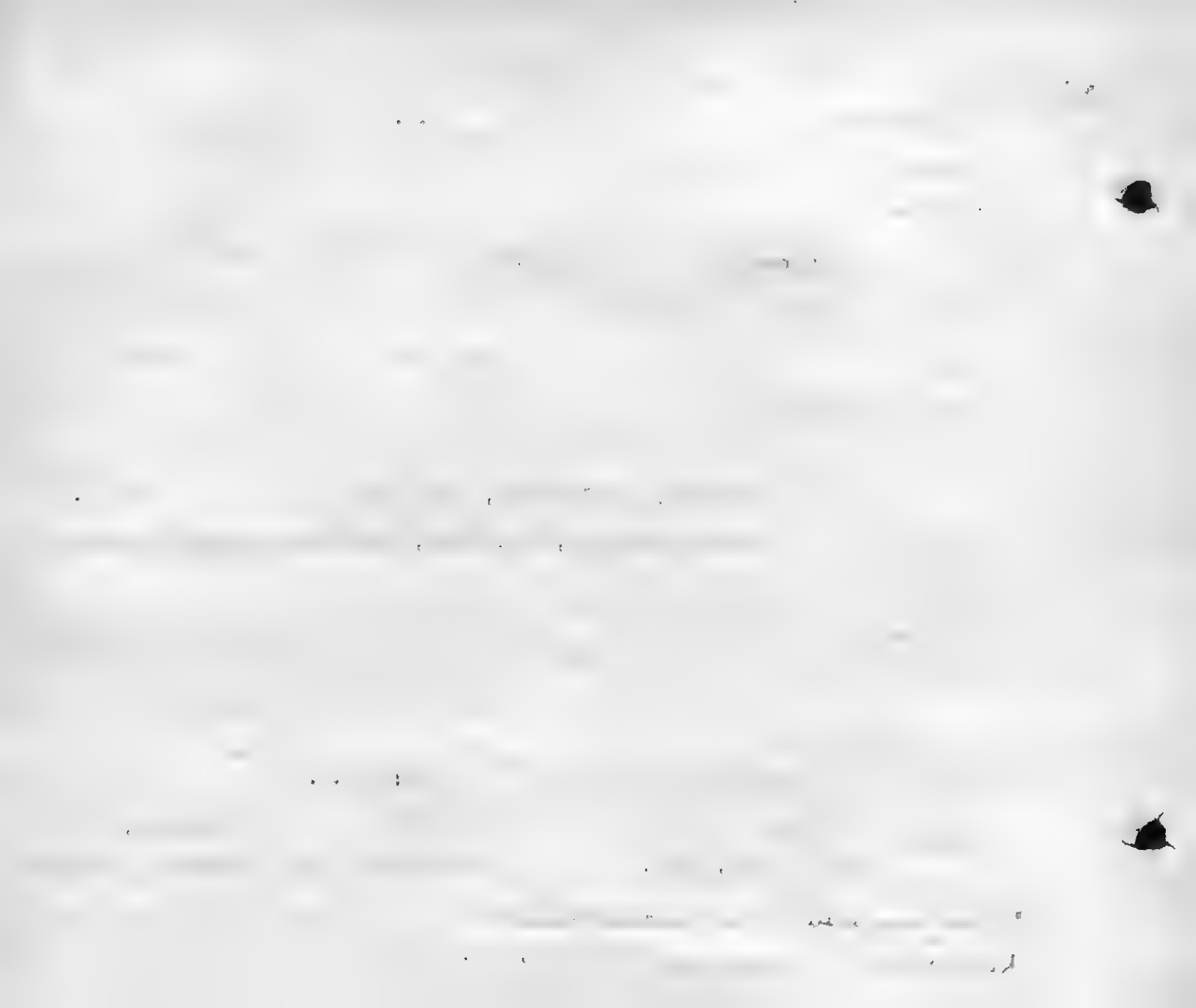
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

8140

CERTIFICATE OF DEATH

08133

1. PLACE OF DEATH a. COUNTY Montgomery		b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN lb Suburban	
2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE D.C.		b. COUNTY Washington		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) 5011 Worthington Drive	
d. STREET ADDRESS 5011 Worthington Drive		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Virginia CARNDUFF		First Middle Last Virginia CARNDUFF		4. DATE OF DEATH Month Day Year 7/28/61 19	
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH August 6, 1911		9. AGE (In years last birthday) 49 yrs.		10. IF UNDER 1 YEAR Months 11 Days 22 Hours Min. 	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Secretary		12. KIND OF BUSINESS OR INDUSTRY ?		13. BIRTHPLACE (Country & State, or foreign country) Maryland	
14. FATHER'S NAME Larkin Glazebrook		15. MOTHER'S MAIDEN NAME Jane Cox		16. CITIZEN OF WHAT COUNTRY? USA	
17. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war and dates of service) no		18. SOCIAL SECURITY NO Unknown		19. INFORMANT Arthur Carnduff (husband) same as above	
20. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) 463 X Pulmonary Embolization, both lungs DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Phlebothrombosis, deep veins, left lower extremity DUE TO (c) 5 days		21. INTERVAL BETWEEN ONSET AND DEATH 20 min.			
22. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) None		23. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
24. MEDICAL CERTIFICATION 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)		21. I certify that (I) (the hospital) attended the deceased from July 25 , 1961 to July 28 , 1961, that (I) (we) last saw the deceased alive on July 28 , 1961, and that death occurred 10:30 A.M. the causes and on the date stated above.		22. DATE SIGNED July 28, 1961	
22a. SIGNATURE Robert G. Angle M.D.		22b. DATE SIGNED July 28, 1961		22c. PHYSICIAN'S NAME (Type) Robert Angle, M.D.	
23a. BURIAL, CREMATION, REMOVAL (Specify) cremation July 28, 1961		23b. DATE THEREOF July 28, 1961		23c. NAME OF CEMETERY OR CREMATORY Cedar Hill	
24. FUNERAL DIRECTOR'S SIGNATURE Robert A. Humphrey		24a. ADDRESS m Bethesda, Md.		25a. REC'D BY REGISTRAR JUL 31 '61	
25b. REGISTRAR'S SIGNATURE William L. Thomas		25c. LOCATION (City, town or county) (State) Prince Georges Maryland			



1
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be retained by the hospital or attending physician and completely filled in by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

1
M
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8141
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH
08134

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND b. CITY OR TOWN (If outside of corporate limits, write RURAL and give nearest town) <u>Takoma Park, Md.</u> c. CITY OR TOWN (If outside of corporate limits, write RURAL and give nearest town) <u>Rockville,</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Washington Sanitarium & Hospital</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (If outside of corporate limits, write RURAL and give nearest town) <u>Rockville,</u> d. STREET ADDRESS <u>1119 Grandin Avenue,</u>	
3. NAME OF DECEASED (Type or print) <u>Baby Girl Caudle</u>		4. DATE OF DEATH <u>7/13/61</u>	
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>7/12/61</u>	
9. AGE (In years last birthday) <u>1</u>		10. IF UNDER 1 YEAR Months <u>1</u> Days <u>4</u> Hours <u>4</u> Min. <u>4</u>	
11a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>no</u>		11b. KIND OF BUSINESS OR INDUSTRY <u>no</u>	
12. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>		13. CITIZEN OF WHAT COUNTRY? <u>America</u>	
14. FATHER'S NAME <u>Robert Allen Caudle</u>		15. MOTHER'S M.A.D.N. NAME <u>Shirley Louise Royce</u>	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		17. SOCIAL SECURITY NO. <u>no</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Asphyxia</u> <u>762.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) <u>congenital central nervous system defect</u> DUE TO (c)		19. INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (b)		20. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		21b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
22a. TIME OF INJURY Month, Day, Year <u>19</u> Hour a.m. <u>19</u> p.m. <u>19</u>		22b. INJURY OCCURRED <u>While at work</u> <input type="checkbox"/> <u>Not while at work</u> <input type="checkbox"/>	
23a. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		23b. (City or town) (County) (State)	
24. I certify that (I) (this hospital) attended the deceased from <u>7/12</u> , 19 <u>61</u> , to <u>7/13</u> , 19 <u>61</u> , that (I) (we) last saw the deceased alive on <u>19</u> , and that death occurred at <u>11</u> M, from the causes and on the date stated above.		25. SIGNATURE <u>Frank G. Leslie</u> M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 7-13-61	
26. PHYSICIAN'S NAME (Type) <u>Frank G. Leslie, M. D.</u>		27. ADDRESS <u>1305 Ballard St., Silver Spring, Md.</u>	
28. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>		29. DATE THEREOF <u>7-15-61</u>	
30. NAME OF CEMETERY OR CREMATORY <u>Washington Sanitarium and Hospital, Takoma Park, Md.</u>		31. LOCATION (City, town or county) (State)	
32. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Hare, M.D.</u>		33. ADDRESS <u>Washington San. & Hospital</u>	
34. REC'D BY REGISTRAR <u>JUL 18 '61</u>		35. REGISTRAR'S SIGNATURE <u>Arthur S. Hume</u>	

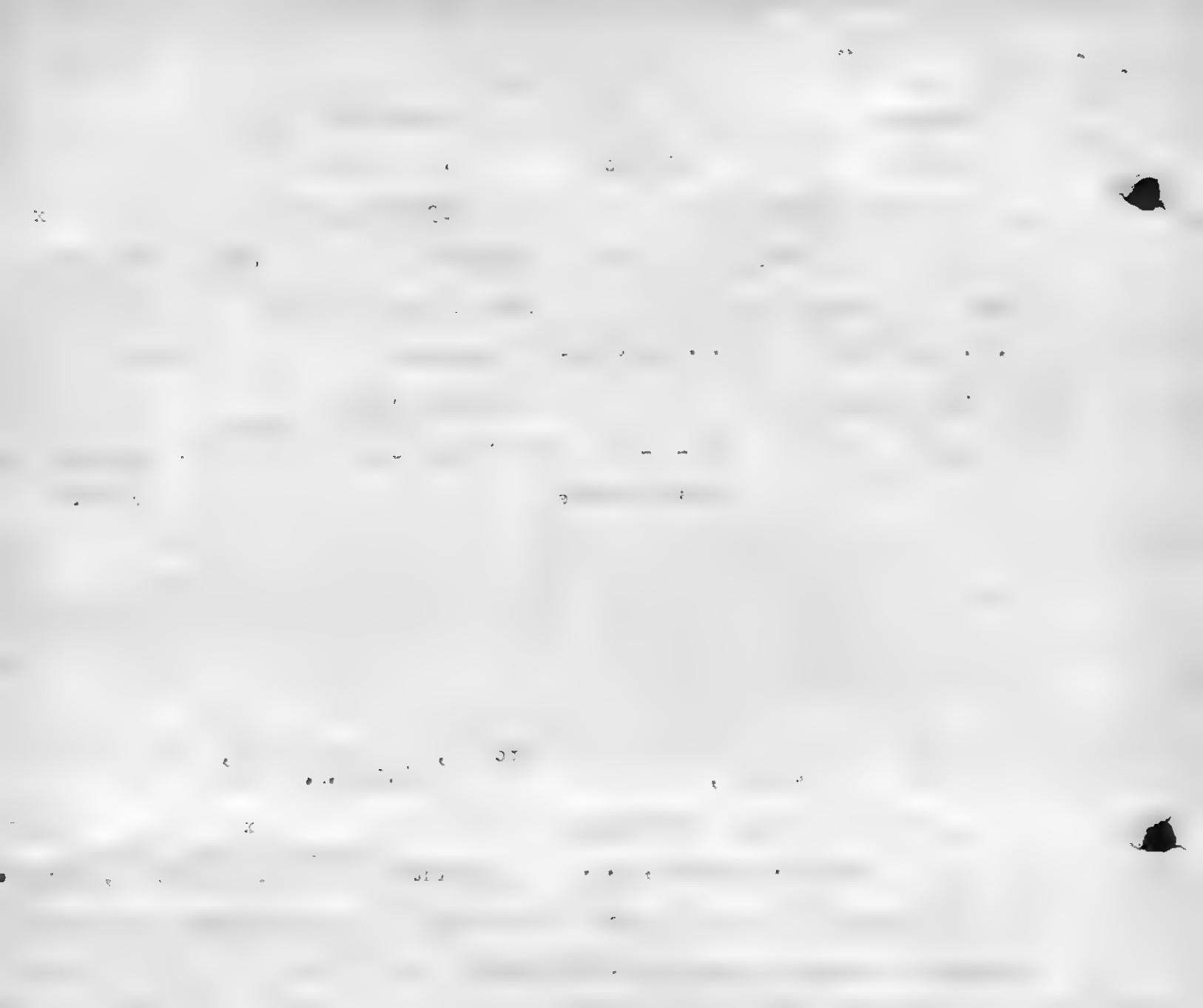
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be retained by the hospital or attending physician. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
8142
CERTIFICATE OF DEATH

08135

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Bethesda c. LENGTH OF STAY (in days) 13 Days d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) The Clinical Center		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Connecticut b. COUNTY New London c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) 13 Ashcraft Road d. STREET ADDRESS 13 Ashcraft Road	
3. NAME OF DECEASED (Type or print) BRUCE PINK CHAMBERS		4. DATE OF DEATH July 10, 1961	
5. SEX Male		6. COLOR OR RACE White	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED		8. DATE OF BIRTH May 19, 1911	
9. AGE (In years, if UNDER 1 YEAR, if UNDER 24 HRS., list birthday) Months Days Hours Min. 50 yrs.		10. BIRTHPLACE (County & State or foreign country) Georgia	
11. CITIZEN OF WHAT COUNTRY? USA		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Pink Chambers		14. MOTHER'S MAIDEN NAME Martha Jackson	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war and dates of service) Yes WW II		16. SOCIAL SECURITY NO. 041-30-0766	
17. INFORMANT The Medical Record		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) Hodgkins Disease 201X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) 1 year	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	
20a. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20b. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	
20c. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> et work et work		20d. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20e. City or town		20f. (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from June 27, 1961 to July 10, 1961 that (I) (we) last saw the deceased alive on July 10, 1961 , and that death occurred at 4:35 a.m. from causes and on the date stated above.			
22a. SIGNATURE Edward S. Henderson		22b. DATE SIGNED 7/10/61	
22c. PHYSICIAN'S NAME (Type) EDWARD S. HENDERSON, M.D.		22d. ADDRESS The Clinical Center, National Institutes of Health, Bethesda 14, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial-Transit 7/10/61		23b. DATE THEREOF 7/10/61	
23c. NAME OF CEMETERY OR CREMATORY Pleasant Grove Cem		23d. LOCATION (City, town or county) (State) Carroll County, Georgia	
24. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey		24. ADDRESS Bethesda, Maryland	
25a. REC'D BY REGISTRAR JUL 11 '61		25b. REGISTRAR'S SIGNATURE Arthur S. Harris	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Part 3 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

8143

08136

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural) c. LENGTH OF STAY IN b. 24 days d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) U. S. Naval Hospital		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Pennsylvania b. COUNTY V c. CITY OR TOWN (If outside of corporate limits, write RURAL and give nearest town) Levittown d. STREET ADDRESS 27 Ailanthus Lane e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Jean Marie CHISARIK		4. DATE OF DEATH July 20 19 61	
5. SEX Female	6. COLOR OR RACE Caucasian	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10-5-32
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY -----	9. AGE (In years last birthday) 28 IF UNDER 1 YEAR: Months 7 Days 1 IF UNDER 24 HRS.: Hours 1 Min. 0
11. BIRTHPLACE (County & State, or foreign country) Pennsylvania		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Edward WOJCIC		14. MOTHER'S MAIDEN NAME Marie JANIK	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. (H) Andrew S. Chisarik, same as #2 above	
17. INFORMANT (H) Andrew S. Chisarik, same as #2 above		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Rheumatic heart disease with DUE TO aortic insufficiency - post operative Conditions, if any which gave rise to immediate cause (a), stating the underlying cause last. one day DUE TO one day PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH? (If either, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (this hospital) attended the deceased from June 26 1961 to July 20 1961 ; that (we) last saw the deceased alive on July 20 1961 , and that death occurred at 11:19 A.M. from the causes and on the date stated above.			
22a. SIGNATURE J. E. McClenathan M.D.		22b. DATE SIGNED 7-20-61	
22c. PHYSICIAN'S NAME (Type) J. E. McClenathan, CDR MC USN		22d. ADDRESS U. S. Naval Hospital, Bethesda, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial-Shipment	23b. DATE THEREOF 7-21-61	23c. NAME OF CEMETERY OR CREMATORY Our Lady of Grace Cemetery	23d. LOCATION (City, town or county) (State) St. Martins Pa.
24. FUNERAL DIRECTOR'S SIGNATURE Thos. Wheeler		25. REGISTRAR'S SIGNATURE Arthur S. Kneiss	
25a. REC'D BY REGISTRAR JUL 24 '61		25b. REGISTRAR'S SIGNATURE Arthur S. Kneiss	

1
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any of the following are necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

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MONTGOMERY STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08137

1. PLACE OF DEATH a. COUNTY MONTGOMERY		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) OLNEY		c. LENGTH OF STAY in 1b 11 DAYS		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE MARYLAND		b. COUNTY MONTGOMERY		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) GERMANTOWN		d. STREET ADDRESS RURAL - RT. 2		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>											
3. NAME OF DECEASED (Type or print) MONTGOMERY GENERAL HOSPITAL		First ALFRED		Middle EUGENE		Last COLEMAN		4. DATE OF DEATH JULY 31 1961		Month JULY		Day 31		Year 1961											
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH 7/16/1880		9. AGE (In years last birthday) 81 yrs.		IF UNDER 1 YEAR Months 81		Days 11		IF UNDER 24 HRS. Hours 11											
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) LABORER		10b. KIND OF BUSINESS OR INDUSTRY FARM		11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U. S. A.		13. FATHER'S NAME WILLIAM COLEMAN		14. MOTHER'S MAIDEN NAME -----		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) -----		16. SOCIAL SECURITY NO. -----											
17. INFORMANT -----		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Broncho-pneumonia, bilateral 703.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Fracture left hip DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) Walking in rear of house when he fell fracturing left hip		19. INTERVAL BETWEEN ONSET AND DEATH 5 days 11 day		20. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from. Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		22a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH.		22b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Walking in rear of house when he fell fracturing left hip		22c. TIME OF INJURY Mon h. Day Y. 7-20 1961		22d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>		22e. PLACE OF INJURY (Home, factory, street, office bldg., etc.) Home		22f. City or town Germantown Montg Md		22g. County Montg		22h. State Md	
23. ACTUAL SIGNATURE Frank J. Broschatt		23. EXAMINER'S NAME (Type) FRANK J. Broschatt		23b. DATE THEREOF 8/2/61		23c. NAME OF CEMETERY OR CREMATORY Forest Oak		23d. LOCATION (City, town, or country) Laithersburg, Maryland		23e. STATE Md		23f. ADDRESS 1331 East Montgomery St Laithersburg, Md		23g. REC'D BY REGISTRAR AUG 3 '61		23h. REGISTRAR'S SIGNATURE Arthur L. Hines									

8145

CERTIFICATE OF DEATH

Reg. Dist. No. 09138

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>313 Silver Spring</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Bartling Nursing Home</u>		d. STREET ADDRESS <u>12807 Flack Street</u>	
3. NAME OF DECEASED (Type or print) <u>Eugene E Collins</u> First Middle Last		4. DATE OF DEATH <u>July 14 1961</u> Month Day Year	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan 9, 1876</u>
9. AGE (In years last birthday) <u>85</u> yrs.		IF UNDER 1 YEAR: Months <u> </u> Days <u> </u> Hours <u> </u> Min <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Buyer-retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Furs</u>	
11. BIRTHPLACE (State or foreign country) <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Charles Collins</u>		14. MOTHER'S MAIDEN NAME <u>Virginia Bohrer</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>214-05-8562</u>	
17. INFORMANT <u>Mrs. Williams-daughter-same 2d</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.00 Congestive Heart Failure</u> DUE TO (b) <u>Arteriosclerotic Heart Disease</u> DUE TO (c) <u>Generalized Arteriosclerosis</u> INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u> <u>10 yrs</u> <u>15 yrs</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>1957</u> to <u>14 July 1961</u> , that I last saw the deceased alive on <u>last week June 1961</u> , and that death occurred at <u>9:00 P</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Merton L. White</u>		ADDRESS (Street, city or town, state) <u>11134 Georgia Ave Silver Spring Md</u>	
PHYSICIAN'S NAME (Type) <u>Merton L. White</u>		DATE SIGNED <u>7/14/61</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>7/17/61</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Greenwood Ch. Cem.</u>	22d. LOCATION (City, town, or county) (State) <u>Morgan County, W. Virginia</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey</u>		ADDRESS <u>Bethesda, Maryland</u>	
24a. REC'D BY REGISTRAR <u>JUL 18 '61</u>		24b. REGISTRAR'S SIGNATURE <u>William S. Kneer</u>	

MEDICAL CERTIFICATION

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

08139

8146

1. PLACE OF DEATH a. COUNTY Montgomery		2. USUAL RESIDENCE (Where deceased lived, if Institution; Residence before admission) a. STATE Maryland b. COUNTY Bethesda	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)		c. LENGTH OF STAY IN 1b 50 days	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) U. S. Naval Hospital		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) South Hampton	
3. NAME OF DECEASED (Type or print) Bertha M-Barbara		d. STREET ADDRESS Bella Vista South Shore Road	
5. SEX Female		4. DATE OF DEATH July 23 1961	
6. COLOR OR RACE Caucasian		8. DATE OF BIRTH 4-23-21	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. AGE (In years last birthday) 40 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		11. BIRTHPLACE (County & State, or foreign country) Washington	
13. FATHER'S NAME Charles F. Ross		12. CITIZEN OF WHAT COUNTRY? USA	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		14. MOTHER'S MAIDEN NAME Hazel D. Moorman	
16. SOCIAL SECURITY NO. (H) Howard R. Combs		17. INFORMANT Same as # 2 Above	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac failure - metabolic 175.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Intestinal obstruction & electrolytic imbalance DUE TO (c) Carcinoma of the ovary			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
MEDICAL CERTIFICATION 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)			
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from June 3, 1961, to July 23, 1961, that (H) (we) last saw the deceased alive on July 23, 1961, and that death occurred at 2:40 AM from the causes and on the date stated above.			
22a. SIGNATURE Arthur O. Anctil Jr.		22b. DATE SIGNED July 24, 1961	
22c. PHYSICIAN'S NAME (Type) Arthur O. Anctil Jr.		22d. ADDRESS U. S. Naval Hospital, Bethesda, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF July 25, 1961	
23c. NAME OF CEMETERY OR CREMATORY Arlington National		23d. LOCATION (City, town or county) (State) Arlington Va.	
24. FUNERAL DIRECTOR'S SIGNATURE Robert Humphrey		25a. REC'D BY REGISTRAR DATE JUL 26 '61	
ADDRESS Robert Humphrey Funeral Home, Bethesda, Md.		25b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR AIS (4)
ISM 9/60

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

8147

C8140

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Washington San & Hosp</u> c. LENGTH OF STAY IN 1b <u>10 days</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Washington San & Hosp</u>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Pasadena</u> b. COUNTY <u>Maryland</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Bayside Beach Drive</u> d. STREET ADDRESS <u>Bayside Beach Drive</u>	
3. NAME OF DECEASED (Type or print) <u>Jefferson Monroe Cook Sr.</u> 5. SEX <u>M</u> 6. COLOR OR RACE <u>W</u> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH <u>9-20-95</u> 9. AGE (in years last birthday) <u>65</u> yrs. IF UNDER 1 YEAR: Months <u>65</u> Days <u>14</u> Hours <u>14</u> Min. <u>1961</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>Farmer</u> 11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u> 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		4. DATE OF DEATH <u>July 14 1961</u>	
13. FATHER'S NAME <u>HENRY COOK</u> 14. MOTHER'S MAIDEN NAME <u>Sarah Frances Chard</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> 16. SOCIAL SECURITY NO. <u>213-20-6930</u> 17. INFORMATION <u>Address</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PA I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Terminal Broncho-pneumonia</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) <u>Generalized Adeno-carcinomatosis</u> DUE TO (c) <u>Adenocarcinoma of Rectum of abdomen</u>		INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u> <u>1 yr</u> <u>2 yrs. + ?</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>July 4, 1961</u> to <u>July 14, 1961</u> , that (I) (we) last saw the deceased alive on <u>July 14, 1961</u> , and that death occurred at <u>11:55 PM</u> , from the causes and on the date stated above.			
22a. SIGNATURE <u>Paul V. Starr</u> 22c. PHYSICIAN'S NAME (Type) <u>Paul V. Starr</u>		22b. DATE SIGNED <u>July 14-1961</u> ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22d. ADDRESS <u>7100 Carroll Ave., Takoma Park, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>July 18, 1961</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Mt. Carmel Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Lake Shore, Pasadena, Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Thomas E. Taylor, Inc.</u>		25a. REC'D BY REGISTRAR <u>JUL 17 '61</u> 25b. REGISTRAR'S SIGNATURE <u>William S. Hanna</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any certificate is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. AISM
SM 9,60

FOR STATE
HEALTH DEPT.

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08141

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u> c. LENGTH OF STAY IN lb <u>3 days</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>902 Newhall St</u>		2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE <u>N. York</u> b. COUNTY <u>Brooklyn</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Brooklyn</u> d. STREET ADDRESS <u>717 55th St</u>	
3. NAME OF DECEASED (Type or print) <u>Anna</u> First <u>Countruman</u> Middle Last		4. DATE OF DEATH Month <u>July</u> Day <u>8</u> Year <u>1961</u>	
5. SEX <u>Female</u>		6. COLOR OR RACE <u>white</u>	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH <u>2-4-1903</u>	
9. AGE (in years last birthday) <u>58</u> yrs.		10. IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u>	
11. BIRTHPLACE (State or foreign country) <u>Conn.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Jos. Greenblatt</u>		14. MOTHER'S MAIDEN NAME <u>UNKNOWN</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>UNKNOWN</u>	
17. INFORMATION <u>EUGENE SCHUBERT</u>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> 420. DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) <u>Found dead in bed</u> (c) <u>Interval between onset and death</u>	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. TIME OF INJURY Month, Day, Year <u>19</u> Hour a.m. <u>19</u> p.m. <u>19</u>	
20c. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20d. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20e. CITY or town: (County) (State)		20f. CITY or town: (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from. Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Frank J. Broscham</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>FRANK J. BROSCHEM</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>7/9/61</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>HEBERT CEM</u>		22d. LOCATION (City, town, or country) <u>WATERBURY, Conn</u>	
22e. ADDRESS <u>Goldberg Funeral Home 4217-9</u>		22f. REC'D BY REGISTRAR <u>Jul 11 '61</u>	
22g. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>		22h. DATE <u>Jul 11 '61</u>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8149

CERTIFICATE OF DEATH

Reg. Dist. No. 00142

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Olney</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>College Park</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Brooke Grove Foundation Inc</u>		d. STREET ADDRESS <u>9608 48th Ave.</u>	
3. NAME OF DECEASED (Type or print) <u>Leighton Journey Crater</u>		4. DATE OF DEATH <u>July 22 1961</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan. 14, 1882</u>
9. AGE (In years, last birthday) <u>79</u> yrs		10. UNDER 1 YEAR IF UNDER 24 HRS	
11a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Hecht company</u>		11b. KIND OF BUSINESS OR INDUSTRY <u>Lamp Department</u>	
11c. BIRTHPLACE (State or foreign country) <u>Olin, D.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>William Crater</u>		14. MOTHER'S MAIDEN NAME <u>Mrs. Journey</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>no</u>	
17. INFORMANT <u>Laura Carmen</u>		Address <u>9608 48th Ave. College Park, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>151X Congestive Heart Failure</u> DUE TO (b) <u>Adenocarcinoma of Stomach</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) <u>3 yrs</u>			INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>6/12</u> , 19 <u>61</u> , to <u>7/22</u> , 19 <u>61</u> , that I last saw the deceased alive on <u>7/22</u> , 19 <u>61</u> , and that death occurred at <u>3:20 P.</u> M., from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>C.H. Libon M.D.</u>		DATE SIGNED <u>7/22/61</u>	
PHYSICIAN'S NAME (Type) <u>C.H. Libon M.D.</u>		ADDRESS (Street, city or town, state) <u>Sandy Springs, Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
<u>Transportation</u>	<u>7/23/61</u>	<u>Wilmington</u>	<u>North Carolina</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>F. Gasch's Sons</u>		ADDRESS <u>Hyattsville, Maryland.</u>	
24a. REC'D BY REGISTRAR <u>JUL 25 '61</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Klaus</u>	

1
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any change is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08143

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural) c. LENGTH OF STAY IN 1b 5½ hours d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) U. S. Naval Hospital		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Virginia b. COUNTY Alexandria c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 123 Martain Street d. STREET ADDRESS 123 Martain Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Christine Monroe DANIEL		4. DATE OF DEATH July 8 19 61		5. SEX Female	
6. COLOR OR RACE Caucasian		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 1-11-50	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Student		10b. KIND OF BUSINESS OR INDUSTRY ---		9. AGE (In years last birthday) 11 yrs.	
11. BIRTHPLACE (State or foreign country) Rhode Island		12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Eddie Lee DANIEL	
14. MOTHER'S MAIDEN NAME Priscella SHIRES		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT (F) Eddie L. Daniel, same as #2 above		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c); PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Shock 7-11-61 DUE TO Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. (b) Removal of heart (c) stab wound in st. ventricle of heart PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I: (e) Carrying knife, tripped, and fell on knife		INTERVAL BETWEEN ONSET AND DEATH 8 hrs	
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. Carrying knife, tripped, and fell on knife		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Off Joplin Road Triangle Virginia	
20c. TIME OF INJURY Hour 8:30 p.m. Month, Day, Year 7-7 19 61		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input checked="" type="checkbox"/> at work Camp Mawavi		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Off Joplin Road Triangle Virginia	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED 7-8-61	
ACTUAL SIGNATURE Frank J. Broschart		M.D. ASS. STANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
EXAMINER'S NAME (Type) Frank J. Broschart, M. D.		Address (Street, city, town, or county) Arlington National Arlington Virginia		22a. LOCATION (City, town, or county) (State) Arlington Virginia	
22b. BURIAL, CREMATION, REMOVAL (Specify) Burial		22c. DATE THEREOF 7-11-61		22d. NAME OF CEMETERY OR CREMATORY Arlington National	
23. FUNERAL DIRECTOR EVERLY		ADDRESS West Funeral Home, 214 W. Main, Fairfax, Va.		24a. REC'D BY REGISTRAR JUL 11 '61	
24b. REGISTRAR'S SIGNATURE Robert J. F...					

MEDICAL CERTIFICATION



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be retained by the hospital or attending physician and completely filled in by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

08144

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>D.C.</u> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington</u>	
c. LENGTH OF STAY IN TB <u>14 days</u>		d. STREET ADDRESS <u>30 PLATTSBURG CT. NW</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>EDNA DAVIS</u>		4. DATE OF DEATH Month Day Year <u>July 27 1961</u>	
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>August 25 1896</u>	
9. AGE (In years last birthday) <u>64</u> yrs.		10. IF UNDER 1 YEAR Months Days <u>64</u>	
11. PLACE OF BIRTH (County & State, or foreign country) <u>MASS.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>William Davis</u>		14. MOTHER'S MAIDEN NAME <u>Ann Rutter</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>014-07-4417</u>	
17. INFORMANT <u>Eva Barney (sister)</u> Address <u>4006 Homer St. Los Angeles California</u>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) a. IMMEDIATE CAUSE (a) <u>CARCINOMA, metastatic</u> b. DUE TO <u>undetermined Primary site</u> c. DUE TO <u>1 yr.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>			
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from... <u>1957</u> to <u>July 27, 1961</u> , that (I) <u>(saw)</u> last saw the deceased alive on... <u>July 27, 1961</u> , and that death occurred at... <u>11:10 A.M.</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>Dr. W. E. DeLanter</u> M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			
22b. DATE SIGNED			
22c. PHYSICIAN'S NAME (Type) <u>DEWITT E. DELANTER</u>			
22d. ADDRESS <u>8025 ABERDEEN RD Bethesda Md</u>			
23a. BURIAL, CREMATION, 23b. DATE THEREOF <u>7/27/61</u>			
23c. NAME OF CEMETERY OR CREMATORY <u>Oak Grove Cem.</u>			
23d. LOCATION (City, town or county) (State) <u>Fall River Mass</u>			
24. FUNERAL DIRECTOR'S SIGNATURE <u>Curry Chase Funeral Home</u> ADDRESS <u>5703 Wisconsin Ave NW DC</u>			
25a. REC'D BY REGISTRAR <u>JUL 31 '61</u> 25b. REGISTRAR'S SIGNATURE <u>Arthur S. Pinner</u>			

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

3152

08145

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ROCKVILLE				c. LENGTH OF STAY IN 1b 12			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 10500 OLD GEORGETOWN ROAD				d. STREET ADDRESS 10500 - OLD GEORGETOWN ROAD			
3. NAME OF DECEASED (Type or print) First FLOYD Middle E. Last DAVIS				4. DATE OF DEATH Month July Day 3 Year 1961			
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10-25-1869	9. AGE (In years last birthday) 91 yrs	10. IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) BANKER		10b. KIND OF BUSINESS OR INDUSTRY — — —		11. BIRTHPLACE (State or foreign country) VIRGINIA		12. CITIZEN OF WHAT COUNTRY U.S.A.	
13. FATHER'S NAME CHARLES WILLIS DAVIS				14. MOTHER'S MAIDEN NAME LUCY MOTHERHEAD			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) [If yes, give war or dates of service]		16. SOCIAL SECURITY NO.		17. INFORMANT Address NORENE S. DAVIS - 10500 OLD GEORGETOWN RD.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Heart Failure 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) Arteriosclerotic Heart Disease DUE TO (c) Generalized Arteriosclerotic Condition							INTERVAL BETWEEN ONSET AND DEATH 24 hrs 18 mos 20 yrs.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Pulmonary Emphysema							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (If this hospital) attended the deceased from April 1960, to July 3 1961, that (If we) last saw the deceased alive on July 2 1961, and that death occurred at 3:45 AM , from the causes and on the date stated above.							
22a. SIGNATURE James J. Foster				22b. ADDRESS 1746 K St. N.W.		22c. PHYSICIAN'S NAME (Type) JAMES J. FOSTER	
22d. ADDRESS 1746 K St. N.W.		22e. DATE JUL 5 '61					
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 7-6-1961		23c. NAME OF CEMETERY OR CREMATORY FORT LINCOLN CEMETERY		23d. LOCATION (City, town, or county) (State) WASHINGTON, DC	
24. FUNERAL DIRECTOR'S SIGNATURE Joseph G. Foster				25a. REC'D BY REGISTRAR DATE JUL 5 '61		25b. REGISTRAR'S SIGNATURE William S. Foster	

(M)

(I)

1
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any change is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08146

1. PLACE OF DEATH
a. COUNTY Montgomery MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rockville
c. LENGTH OF STAY IN 1b D.O.A.
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Fells Rd. Golf Course

2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)
a. STATE md b. COUNTY montg
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring
d. STREET ADDRESS 205 Indian Spring Dr.

3. NAME OF DECEASED (Type or print) James Bernard Davis
First Middle Last
4. DATE OF DEATH July 7 1961
Month Day Year
5. SEX Male 6. COLOR OR RACE White 7. MARRIED ☒ NEVER MARRIED ☐ 8. DATE OF BIRTH 12-27-14
9. AGE (In years, last birthday) 46 yrs. 6 Months 11 Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Lawyer 10b. KIND OF BUSINESS OR INDUSTRY Own Business 11. BIRTHPLACE (State or foreign country) Pennsylvania 12. CITIZEN OF WHAT COUNTRY? U.S.C.

13. FATHER'S NAME Timothy W. Davis 14. MOTHER'S MAIDEN NAME Mary A. Pierrihan

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No 16. SOCIAL SECURITY NO. 159 16 0315 17. INFORMANT Nadine P. Davis
205 E. Indian Spring Dr.
Silver Spring, Md.

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Coronary occlusion
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: } DUE TO
(b)
(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a).
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH. 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part I of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 20d. INJURY OCCURRED While at work ☐ Not While at work ☐ 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐ inspection ☒ Inquiry ☒ and in my opinion death resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☐ DEPUTY MEDICAL EXAMINER ☒ DATE SIGNED 7-7-61

ACTUAL SIGNATURE Frank J. Brosch EXAMINER'S NAME (Type) FRANK J. Brosch Address (Street, city, town, or county)

22a. BURIAL OR CREMATION (Specify) XXXXXX 22b. DATE THEREOF 7-11-61 22c. NAME OF CEMETERY OR CREMATORY Gate of Heaven 22d. LOCATION (City, town, or country) (State) Montgomery Md.

23. FUNERAL DIRECTOR WARNER E. PUMPHREY INC. ADDRESS 8434 Georgia Ave. Silver Spring, Md. 24a. REC'D BY REGISTRAR JUL 11 '61 24b. REGISTRAR'S SIGNATURE Arthur L. Hunt



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

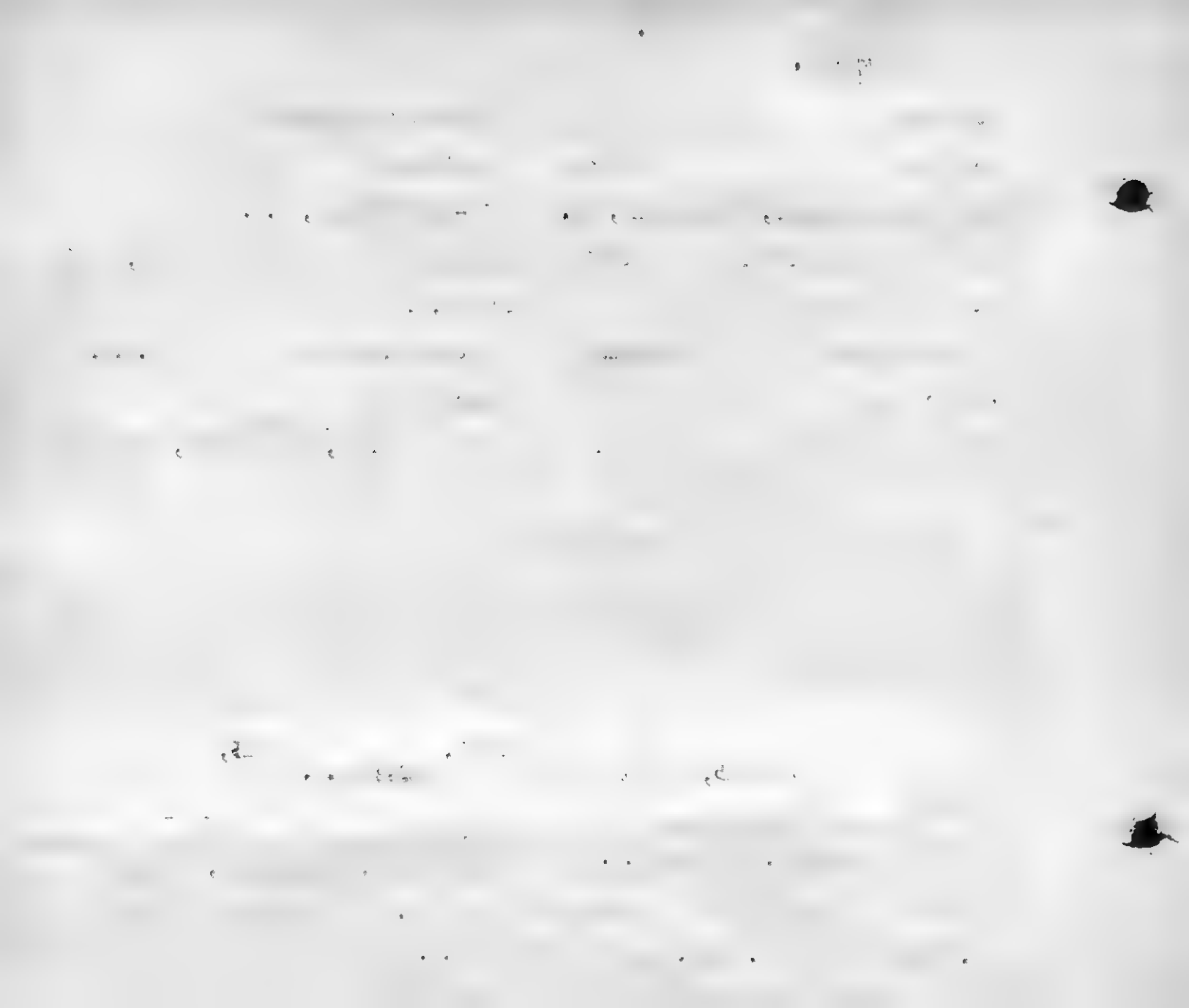
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

2154

new film 691 6/21/61 ink

08147

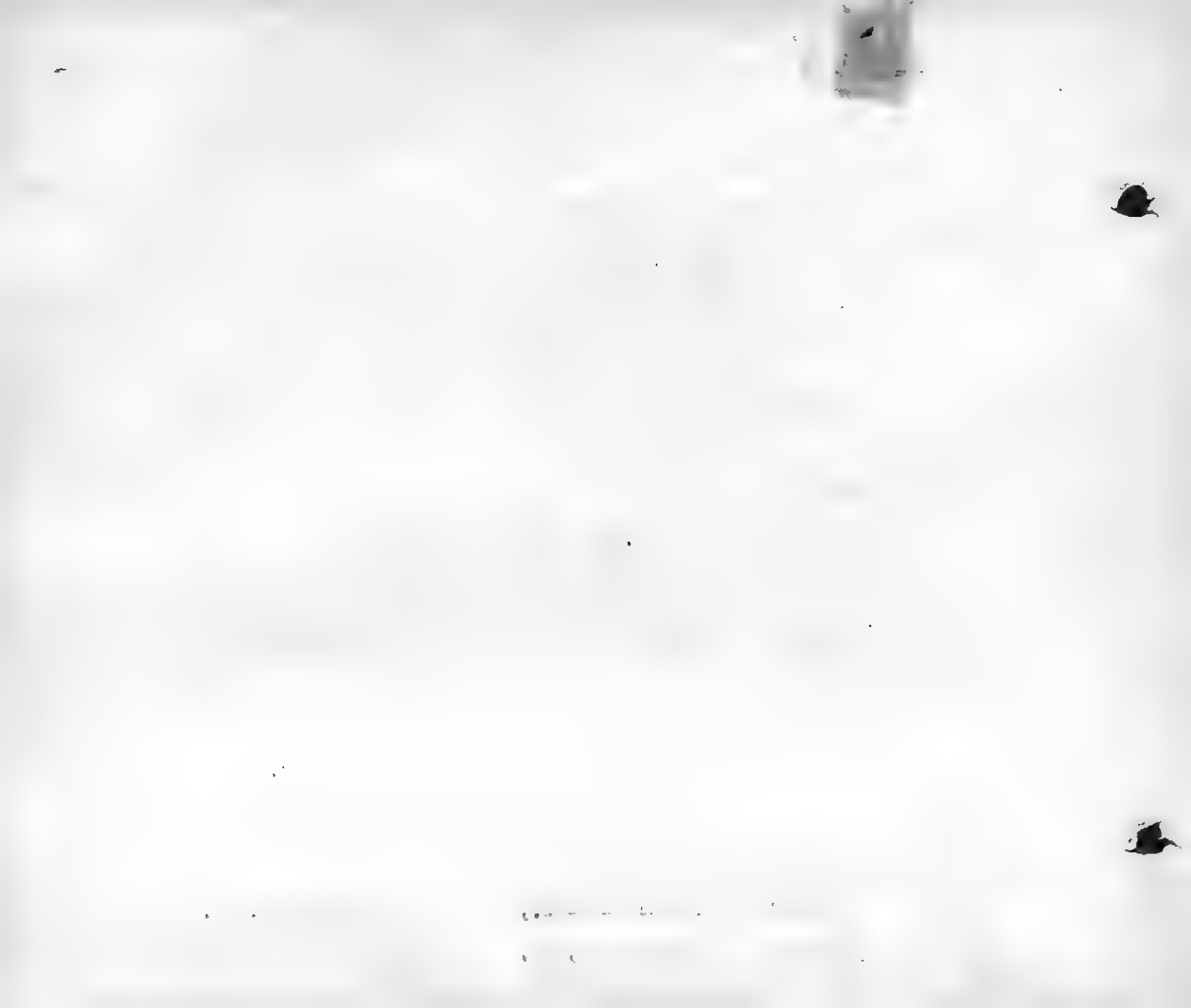
1. PLACE OF DEATH a. COUNTY Montgomery		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE District of Columbia b. COUNTY District of Columbia	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) The Clinical Center, Bethesda 14, Md.		d. STREET ADDRESS 37 - 47th Street, S.E.	
3. NAME OF DECEASED (Type or print) Jasper Lonnie Davis		4. DATE OF DEATH July 16, 1961	
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 23, 1919
9. AGE (In years last birthday) 42 yrs.		10. IF UNDER 1 YEAR Months 1 Days 1 Hours 1 Min. 1	
11a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Offset Pressman		11b. KIND OF BUSINESS OR INDUSTRY Printing	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Jasper Davis	
14. MOTHER'S MAIDEN NAME Nancy Byrd		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes WW II	
16. SOCIAL SECURITY NO. Unavailable		17. INFORMANT The Medical Record	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Embolism 444X DUE TO Conditions, if any, which gave rise to immediate cause (b) Essential Hypertension (c) due to PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) yes			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, notify medical examiner) <input type="checkbox"/>			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from June 21, 1961 to July 15, 1961, that (I) (we) last saw the deceased alive on July 15, 1961, and that death occurred July 16, 1961 at 12:30 A.M. from the causes and on the date stated above.			
22a. SIGNATURE Thomas E. Gaffney		22b. DATE SIGNED 7-16-61	
22c. PHYSICIAN'S NAME (Type) Thomas E. Gaffney M.D.		22d. PLACE OF DEATH The Clinical Center, National Institutes of Health, Bethesda 14, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF July 20, 1961	
23c. NAME OF CEMETERY OR CREMATORY Arlington National Cem.		23d. LOCATION (City, town or county) Arlington, Virginia	
24. FUNERAL DIRECTOR'S SIGNATURE W. Ernest Jarvis Co., Inc.		25a. REC'D BY REGISTRAR Jul 19 1961	
25b. REGISTRAR'S SIGNATURE Arthur S. Thomas			



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

08143

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda				c. LENGTH OF STAY IN 1b 2 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Suburban				d. STREET ADDRESS 805 Westmore Ave.			
3. NAME OF DECEASED (Type or print) First Larrington Middle E. Davis Last				4. DATE OF DEATH Month July Day 15 Year 1961			
5. SEX Male		6. COLOR OR RACE Col.		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 10/5/40	
9. AGE (In years last birthday) 20 yrs		IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min 0		IF UNDER 24 HRS Hours 0 Min 0		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	
10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Frederick, Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A			
13. FATHER'S NAME Edward W. Davis				14. MOTHER'S MAIDEN NAME Ellen Louise Nickens			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT Father, Same as above	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary edema 292.6 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Circulatory failure DUE TO (c) PART II. OTHER'S GNIF CANT CONDIT ONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Sickle cell anemia						INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month. 19 Day. 19 Year. 1961 Hour a. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 7/11/61 to 7/15/61 that (I) (we) last saw the deceased alive on 7/15/61 and that death occurred at 10:00 AM from the causes and on the date stated above							
22a. SIGNATURE Stephen N. Jones M.D.				ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22b. DATE SIGNED 7/15/61	
22c. PHYSICIAN'S NAME (Type) Stephen N. Jones				22d. ADDRESS Rockville, Md.			
23a. BURIAL, CREMATION, or REMOVAL (Specify) Burial		23b. DATE THEREOF 7/20/61		23c. NAME OF CEMETERY OR CREMATORY Lincoln Park.		23d. LOCATION (City, town, or county) (State) Rockville, Md.	
24. BY DIRECTOR OF HEALTH Robert L. Snowden				25a. REC'D BY REGISTRAR DATE Jul 24 '61		25b. REGISTRAR'S SIGNATURE Arthur S. Kraus	



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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(M)

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

8156

08149

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>KENSINGTON MD</u> c. LENGTH OF STAY IN 1b <u>YEARS</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>CARROLL HALL</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>MONTGOMERY</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>GARRETT PK MD</u> d. STREET ADDRESS <u>10800 KESWICK ST</u>	
3. NAME OF DECEASED (Type or print) <u>HARRIET HOLMES DEFENDORF</u> First Middle Last		4. DATE OF DEATH <u>7</u> <u>21</u> <u>1961</u> Month Day Year	
5. SEX <u>F</u> <u>W</u> 6. COLOR OR RACE <u>W</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>8/19/63</u> 9. AGE (In years last birthday) <u>97</u> yrs. IF UNDER 1 YEAR Months <u>11</u> Days <u>2</u> IF UNDER 24 HRS. Hours <u></u> Min. <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u> 10b. KIND OF BUSINESS OR INDUSTRY <u></u> 11. BIRTHPLACE (County & State or foreign country) <u>OHIO</u> 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>JAMES M. HOLMES</u> 14. MOTHER'S MAIDEN NAME <u>FRANCES TURNER</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> 16. SOCIAL SECURITY NO. <u></u> 17. INFORMANT <u>ELIZ. WEAVER, 10800 KESWICK, GAR. PK.</u> Address <u></u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) <u>Arteriosclerotic HEART DISEASE</u> <u>1/20/0</u> DUE TO <u>GENERALIZED ARTERIOSCLEROSIS</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (c) <u></u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) <u></u>	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/> 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u></u> 20c. TIME OF INJURY Month, Day, Year <u>19</u> Hour a.m. <u></u> p.m. <u></u> 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u></u> 20f. (City or town, (County) (State) <u></u>	
21. I certify that (I) (this hospital) attended the deceased from <u>7/5/61</u> , 19 <u>61</u> to <u>7/21</u> , 19 <u>61</u> that (I) (we) last saw the deceased alive on <u>7/21</u> , 19 <u>61</u> , and that death occurred at <u>1500h</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>Richard H. Pollen</u> 22c. PHYSICIAN'S NAME (Type) <u>RICHARD H. POLLEN</u>		22b. DATE SIGNED <u>7/21/61</u> 22d. ADDRESS <u>10511 SUMMIT AVE KENS, MD</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> 23b. DATE THEREOF <u>7/25/1961</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Arlington National</u> 23d. LOCATION (City, town or county) (State) <u>Arlington Virginia</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey</u> ADDRESS <u>Bethesda, Maryland</u>		25a. REC'D BY REGISTRAR <u>DATE JUL 25 '61</u> 25b. REGISTRAR'S SIGNATURE <u>Arthur S. Harris</u>	



8157

CERTIFICATE OF DEATH

Reg. Dist. No. 08150

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>Mont. Co.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockville</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban</u>		d. STREET ADDRESS <u>1209 Monroe Ave.</u>	
3. NAME OF DECEASED (Type or print) First <u>Thomas L.</u> Middle <u>Hillinger</u> Last <u></u>		4. DATE OF DEATH Month <u>July</u> Day <u>15</u> Year <u>1961</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>2/27/1900</u>
9. AGE (In years last birthday) <u>61</u> yrs.		10. UNDER 1 YEAR IF UNDER 24 HRS Months <u></u> Days <u></u> Hours <u></u> Min. <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Funeral manager</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Funeral</u>	
11. BIRTHPLACE (State or foreign country) <u>Ill.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Joseph Hillinger</u>		14. MOTHER'S MAIDEN NAME <u>Dorothy Ann Walters</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>yes</u> (If yes, give year or dates of service) <u>Army 1942-1945</u>		16. SOCIAL SECURITY NO. <u>209-05-6879</u>	
17. INFORMANT <u>Thomas Hillinger</u>		Address <u>15800 1st Ave</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumonia</u> DUE TO (b) <u>Metastasis Cerebral</u> DUE TO (c) <u></u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.		INTERVAL BETWEEN ONSET AND DEATH <u>1 yr</u> <u>1 month</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>6/22/61</u> , 19 <u>61</u> to <u>July 15</u> , 19 <u>61</u> , that I last saw the deceased alive on <u>July 15</u> , 19 <u>61</u> , and that death occurred at <u>12:00</u> M., from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>W. S. Murphy</u>		M.D. <u>Rockville Md</u> DATE SIGNED <u>July 16, 1961</u>	
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>	22b. DATE THEREOF <u>7/19/61</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Washington Hall</u>	22d. LOCATION (City, town, or county) (State) <u>Washington MD</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>W. W. Chambers Co.</u>		ADDRESS <u>517 11th St SE Wash. DC</u>	
24a. REC'D BY REGISTRAR <u>JUL 18 '61</u>		24b. REGISTRAR'S SIGNATURE <u>C. L. S. Frank</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL FOR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be retained by the hospital or attending physician. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
8158
CERTIFICATE OF DEATH

08151

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u> c. LENGTH OF STAY IN town <u>7 hrs.</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Camp Springs</u> d. STREET ADDRESS <u>6226 - Allentown Rd.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Annie Elizabeth Lodge</u> First Middle Last 4. DATE OF DEATH <u>July 6</u> 19 <u>61</u> Month Day Year		5. SEX <u>female</u> 6. COLOR OR RACE <u>white</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH <u>5/16/1917</u> 9. AGE (In years, if under 1 year, if under 24 hrs. last birthday) <u>44</u> yrs. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>retired</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>Bureau of Eng. Washington, D.C.</u> 11. BIRTHPLACE (County & State, or foreign country) <u>U. S. A.</u> 12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>		13. FATHER'S NAME <u>Johnson</u> 14. MOTHER'S MAIDEN NAME <u>Nora Flynn</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? <u>no</u> (Yes, no, or unknown) (If yes, give year or dates of service) 16. SOCIAL SECURITY NO. <u>121137211</u> 17. INFORMATION <u>Mrs. Anna C. Miller / Wash. D.C.</u> Address		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Coronary Thrombosis</u> DUE TO <u>Coronary Hypertensive heart disease</u> Conditions, if any, which gave rise to immediate cause (b) <u>3 yrs.</u> (a), stating the underlying cause last. (c)	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u> 20d. INJURY OCCURRED White <input type="checkbox"/> Not White <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>1959</u> to <u>7/6/61</u> , that (I) (we) last saw the deceased alive on <u>7/6/61</u> , and that death occurred <u>10:30 PM</u> from the causes and on the date stated above. 22a. SIGNATURE <u>Bernard J. Walsh</u> M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22b. DATE SIGNED <u>7/6/61</u> 22c. PHYSICIAN'S NAME (Type) <u>Bernard J. Walsh</u> 22d. ADDRESS <u>1800 Eye St. S.W.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> 23b. DATE THEREOF <u>7-10-1961</u> 23c. NAME OF CEMETERY OR CREMATORY <u>Mt. Olivet</u> 23d. LOCATION (City, town or county) (State) <u>Washington, D.C.</u>		24. FUNERAL DIRECTOR'S SIGNATURE <u>R. P. Walther</u> ADDRESS <u>131-11th St. N.E.</u> 25a. REC'D BY REGISTRAR <u>JUL 10 '61</u> 25b. REGISTRAR'S SIGNATURE <u>Arthur S. Frank</u>	

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death.

may be relied upon by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Items 5,6,7 & 14 Film 3-92 8/9/01 iwk

CERTIFICATE OF DEATH

Reg. Dist. No. 08152

8159

1 PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived. If institution Res dence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montg.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Wheaton</u>		c. LENGTH OF STAY IN 1b <u>life</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>1511 Wheaton Lane</u>		d. STREET ADDRESS <u>11511 Wheaton Lane</u>	
3 NAME OF DECEASED (Type or print) <u>Augustus</u> First <u>Dorsey</u> Middle <u>Dorsey</u> Last		4. DATE OF DEATH <u>July</u> Month <u>30</u> Day <u>1961</u> Year	
5. SEX <u>Male</u>	6 COLOR OR RACE <u>Colored</u>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Apr. 27, 1889</u> Yrs <u>72</u>
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Custodian</u>		10b KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12 CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Frank Dorsey</u>		14 MOTHER'S MAIDEN NAME <u>Mary Clark</u>	
15 WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16 SOCIAL SECURITY NO. <u>INFORMANT</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]		Address <u>1511 Wheaton Lane, Wheaton, Md.</u>	
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis</u>		INTERVAL BETWEEN ONSET AND DEATH <u>2 months</u>	
332X DUE TO (b) <u>Arteriosclerotic Hypertension</u>			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE-CONDITION GIVEN IN PART I (a) <u>Prostatic Hypertrophy</u> <u>Sagittal Hernia</u> <u>Arthritis</u>			
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town), (County), (State)	
21. I certify that I attended the deceased from <u>Sept. 5, 1935</u> , to <u>July 30, 1961</u> , that I last saw the deceased alive on <u>July 29, 1961</u> , and that death occurred at <u>1:10 PM</u> , from the causes and on the date stated above			
ACTUAL SIGNATURE <u>Robert L. Snowden</u> M.D.		DATE SIGNED <u>Aug 8, 1961</u>	
PHYSICIAN'S NAME (Type) <u>WEBSTER SEWELL</u>		<u>Robert L. Snowden, Rockville, Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
<u>BURIAL</u>	<u>8-4-61</u>	<u>West Liberty</u>	<u>West Liberty, Howard Co., Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert L. Snowden</u>		24a. REC'D BY REGISTRAR <u>Aug 7 '61</u>	
ADDRESS <u>Rockville, Md.</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hanks</u>	



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08153

8160

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any cause is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
SM 7/59

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Rockville</u>	
c. LENGTH OF STAY IN 1b <u>D.O.A.</u>		d. STREET ADDRESS <u>1 Olney Georgetown Road</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Suburban Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
NAME OF DECEASED (Type or print) <u>Elzy Edward Dove</u>		4. DATE OF DEATH <u>July 10 1961</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 5, 1907</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Construction</u>	
11. BIRTHPLACE (State or foreign country) <u>Rockville Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Robert Edward Dove</u>		14. MOTHER'S MAIDEN NAME <u>Florida Jane Hogan</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>214-16-7458</u>	
17. INFORMANT <u>Mrs. Eleanor Dove</u>		Address <u>As above</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) <u>442X Acute Congestive heart failure</u> Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last, } (b) <u>Chronic Cardio-renal disease</u> (c) <u>As above</u>		INTERVAL BETWEEN ONSET AND DEATH <u>sudden</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I, (e) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year <u>19</u> Hour a.m. p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Frank J. Broschert</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>FRANK J. Broschert</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>7/13/61</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Lincoln Park,</u>		22d. LOCATION (City, town, or country) (State) <u>Rockville, Md.</u>	
23. FUNERAL DIRECTOR <u>Robert L. Snowden</u>		24a. REC'D BY REGISTRAR <u>JUL 17 '61</u>	
ADDRESS <u>Rockville Md</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Harris</u>	

MEDICAL CERTIFICATION

FOR STATE HEALTH DEPT

TO DEPARTMENT OF MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, end in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND MEDICAL EXAMINER'S CERTIFICATE OF DEATH

8161 C8154

1. PLACE OF DEATH
a. COUNTY Montgomery MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Takoma Park, D.C.A.
c. LENGTH OF STAY IN 1b 10
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Wash San & Hosp

2. USUAL RESIDENCE (Where deceased lived, if last full residence before admission)
a. STATE Maryland b. COUNTY Pr. Georges
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hyattsville
d. STREET ADDRESS 5624 31st Ave

3. NAME OF DECEASED (Type or print) Thomas Gladman Dowling
First Middle Last
4. DATE OF DEATH 7-9-61 Month Day Year
5. SEX W 6. COLOR OR RACE M 7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐ 8. DATE OF BIRTH 9-10-04 9. AGE (in years last birthday) 56 10. IF UNDER 1 YEAR: Months 5 Days 12 11. IF UNDER 24 HRS: Hours 12 Min. 00

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Bricklayer 10b. KIND OF BUSINESS OR INDUSTRY CONSTRUCTION 11. BIRTHPLACE (State or foreign country) DIST. of Columbia 12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME THOMAS DOWLING 14. MOTHER'S MAIDEN NAME UNKNOWN

15. WAS DECEASED EVER IN U.S. ARMED FORCES? NO 16. SOCIAL SECURITY NO. 31 me 615 above 17. INFORMANT MRS. ANNA DENT Address 31 me 615 above

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cornary occlusion
Conditions, if any, which gave rise to immediate cause (b) 420.1
(a), stating the underlying cause last. (c) DUE TO

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I: History of previous heart disease

20a. EXTERNAL CAUSE (AS PRIMARY ☐ OR CONTRIBUTING CAUSE OF DEATH) DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year 19 20d. INJURY OCCURRED While ☐ at work Not While ☐ at work 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐ inspection ☒ Inquiry ☒ and in my opinion death resulted from. Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE Frank J. Broschant CHIEF MEDICAL EXAMINER ☐
EXAMINER'S NAME (Type) FRANK J. Broschant M.D. ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒ DATE SIGNED 7-9-61
Address (Street, city, town, or county)

22a. BURIAL, CREMATION, or REMOVAL (Specify) BURIAL 22b. DATE THEREOF 7-12-61 22c. NAME OF CEMETERY OR CREMATORY CEDAR HILL CEM 22d. LOCATION (City, town, or county) (State) SUITLAND, MARYLAND

23. FUNERAL DIRECTOR W. W. Chambers Co. Riverdale, Md. ADDRESS W. W. Chambers Co. Riverdale, Md. 24a. REC'D BY REGISTRAR JUL 12 '61 24b. REGISTRAR'S SIGNATURE Arthur S. K...



3162

09155

1 PLACE OF DEATH a. COUNTY <u>Maryland</u>		2 USUAL RESIDENCE (Where deceased lived. If institution. Residence before admission) a STATE <u>B. C.</u> b COUNTY	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c LENGTH OF STAY IN 1b <u>1 yr 4 mo. 15 dy</u>	
d NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>CUNY MANOR SAN. 4200 WISCONSIN AVE</u>		d. STREET ADDRESS <u>3221 Jocelyn</u>	
3 NAME OF DECEASED (Type or print) <u>Gertrude</u>		4. DATE OF DEATH Month <u>July</u> Day <u>3</u> Year <u>1961</u>	
5 SEX <u>F</u>	6 COLOR OR RACE <u>W</u>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>4/9/1877</u>
9a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		9b. KIND OF BUSINESS OR INDUSTRY	
10a. BIRTHPLACE (State or foreign country) <u>Washington D. C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>William Allison</u>		14. MOTHER'S MAIDEN NAME <u>Ada Adams</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16 SOCIAL SECURITY NO <u>None</u>	
17 INFORMANT <u>Mrs W. King</u>		Address <u>3221 Jocelyn St. D.C.</u>	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>congestive heart failure (Generalized)</u> DUE TO (b) <u>arterio sclerosis</u> DUE TO (c) <u>accident</u>		INTERVAL BETWEEN ONSET AND DEATH <u>24 hrs.</u>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21 I certify that (I) (this hospital) attended the deceased from <u>Feb. 8</u> 19 <u>54</u> to <u>July 3</u> 19 <u>61</u> . that (I) (we) last saw the deceased alive on <u>July 2</u> 19 <u>61</u> , and that death occurred at <u>2:30</u> P. M. from the causes and on the date stated above.			
22a SIGNATURE <u>Leland E. Stevenson</u>		22b DATE SIGNED <u>7-3-61</u>	
22c PHYSICIAN'S NAME (Type) <u>LELAND E. STEVENSON</u>		22d ADDRESS <u>2101-R. ST. N.W. D.C. 8.</u>	
23a BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		23b DATE THEREOF <u>7/5/61</u>	
23c NAME OF CEMETERY OR CREMATORY <u>Rock Creek Cemetery</u>		23d LOCATED ON (City, town, or county) (State) <u>Washington, D. C.</u>	
24 FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey</u>		25a REC'D BY REGISTRAR <u>Jul 6 1961</u>	
25b REGISTRAR'S SIGNATURE <u>Arthur S. ...</u>			

MARYLAND STATE DEPARTMENT OF HEALTH
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

8163

CERTIFICATE OF DEATH

09268

1 PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Boyd's</u>	
c. LENGTH OF STAY IN TB <u>4 days</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban</u>		d. STREET ADDRESS <u>1 Box 114 Route 1</u>	
3 NAME OF DECEASED (Type or print) <u>Baby</u> First <u>Boy</u> Middle <u>Duffin</u> Last <u>Duffin</u>		4. DATE OF DEATH <u>July 31</u> Month <u>July</u> Day <u>31</u> Year <u>1961</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>colored</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 27, 1961</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Lorenzo Duffin</u>		14. MOTHER'S MAIDEN NAME <u>Annie Palmer</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/> (If yes, give year or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Father (Lorenzo Duffin)</u>		Address <u>same as above</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>PULMONARY ATELECTASIS</u> DUE TO (b) <u>PREMATURITY</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>7-31</u> 19 <u>61</u> , to <u>7-31</u> 19 <u>61</u> , that (I) (we) last saw the deceased alive on <u>7-31</u> 19 <u>61</u> , and that death occurred at <u>7-31</u> M, from the causes and on the date stated above			
22a. SIGNATURE <u>Robert C. Warthen</u>		22b. DATE SIGNED <u>8-1-61</u>	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>CREMATION</u>	23b. DATE THEREOF <u>8/3/61</u>	23c. NAME OF CEMETERY OR CREMATORY <u>SUBURBAN HOSPITAL</u>	23d. LOCATION (City, town, or county) (State) <u>OLD GEORGETOWN, BETHESDA, MD.</u>
24. FUNERAL DIRECTOR'S SIGNATURE <u>AMELIA CARTER - ADMINISTRATION</u>		25a. REC'D BY REGISTRAR <u>AUG 10 '61</u>	25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kinas</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages may be retained by the hospital or attending physician and completely filled in by the funeral director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
8164
CERTIFICATE OF DEATH

08157

1. PLACE OF DEATH a. COUNTY MONTGOMERY b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BETHESDA c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) SUBURBAN HOSPITAL		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY WASHINGTON D.C. c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) WASHINGTON D.C. d. STREET ADDRESS 1706 KENYON ST NW	
3. NAME OF DECEASED (Type or print) MARY McNeil DUNLAP		4. DATE OF DEATH JULY 23 19 61	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 21, 1898
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Homemaker		11. BIRTHPLACE (County & State, or foreign country) Mississippi	
13. FATHER'S NAME William R. Dunlap		14. MOTHER'S MAIDEN NAME Elizabeth Johnson	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no		17. INFORMANT (Sister) Mrs. Daniel B. Ventres Address Washington, D.C. 3407 - 34th Place, N.W.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral accident with hemiplegia, right DUE TO arteriosclerosis with chronic nephritis. Conditions, if any, which gave rise to immediate cause (b) arteriosclerosis with chronic nephritis. (a), stating the underlying cause last. (c) arteriosclerosis with chronic nephritis.		INTERVAL BETWEEN ONSET AND DEATH July 18, '61	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)			
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) Curious teeth		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Hour a.m. 19 p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Washington, D. C.	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from July 18, '61 to July 23, 19 61 that (I) (we) last saw the deceased alive on July 22, 1961 , and that death occurred at 4 A M, from the causes and on the date stated above.			
22a. SIGNATURE Oliver E. Thompson		22b. DATE SIGNED 7-23-61	
22c. PHYSICIAN'S NAME (Type) DR OLIVER THOMPSON		22d. ADDRESS 901 PERSHING Dr, SILVER SPRING MD	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 7/26/61	23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery	23d. LOCATION (City, town or county) (State) Prince Georges County, Md.
24. FUNERAL DIRECTOR'S SIGNATURE Arthur S. Kraus		25a. REC'D BY REGISTRAR Arthur S. Kraus	
25b. REGISTRAR'S SIGNATURE Arthur S. Kraus		25c. REC'D BY REGISTRAR JUL 25 '61	



8165

CERTIFICATE OF DEATH

Reg. Dist. No. 08156

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution Residence before admision) a. STATE Maryland b. COUNTY Prince George ✓			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Springs Md.				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 9340 Lanham Severn Road			
c. LENGTH OF STAY IN 1b 9 months				d. STREET ADDRESS Lanham, Maryland			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Althea Woodling Nursing Home				e. IS RES DENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Emily Middle Dunlop Last Dunlop				4. DATE OF DEATH Month July Day 30 Year 19 61			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH July 17, 1873	
9. AGE (In years last birthday) 88 yrs.		IF UNDER 1 YEAR Months 88 Days 88 Hours 88 Min 88		IF UNDER 24 HRS Months 88 Days 88 Hours 88 Min 88			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired				10b. KIND OF BUSINESS OR INDUSTRY Rooming House		11. BIRTHPLACE (State or foreign country) Wisconsin	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME August Pomeroy				14. MOTHER'S MAIDEN NAME Augusta Schoening			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) no				16. SOCIAL SECURITY NO. no			
17. INFORMANT Mrs Joseph Yuill				Address Hyattsville Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) INTESTINAL OBSTRUCTION DUE TO ADVANCED ARTERIOSCLEROSIS Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO (b) ADVANCED ARTERIOSCLEROSIS DUE TO (c) ADVANCED ARTERIOSCLEROSIS							INTERVAL BETWEEN ONSET AND DEATH 36 hours Years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				(County)		(State)	
21. I certify that I attended the deceased from 11/4 , 1960, to 7/30 , 1961, that I last saw the deceased alive on 7/29 , 1961, and that death occurred at 8:45 M, from the causes and on the date stated above.							
ACTUAL SIGNATURE C. Louis Mendel				ADDRESS (Street, city or town, state) 4506 COLLEGE AVE			
DATE SIGNED 7/30/61							
PHYSICIAN'S NAME (Type) C. LOUIS MENDEL				COLLEGE PARK, Md			
22a. BURIAL, CREMATION, REMOVAL (Specify) Cremation		22b. DATE THEREOF Aug 1, 1961		22c. NAME OF CEMETERY OR CREMATORY Ft Lincoln Crematory		22d. LOCATION (City, town, or county) (State) Colmar Manor, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons				ADDRESS Hyattsville, Md.		24a. REC'D BY REGISTRAR DATE AUG 3 '61	
				24b. REGISTRAR'S SIGNATURE Arthur S. Kraus			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

02159

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda, Maryland</u> c. LENGTH OF STAY IN lb <u>5 days</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Suburban</u>		2. USUAL RESIDENCE (Where deceased lived, if not before admission) a. STATE <u>Washington</u> b. COUNTY <u>D.C.</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>4423 Alton Place N.W.</u> d. STREET ADDRESS <u>4423 Alton Place N.W.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF (Type or print) <u>EFFIE</u> First <u>S.</u> Middle <u>DUVALL</u> Last		4. DATE OF DEATH <u>7</u> Month <u>20</u> Day <u>1961</u> Year			
5. SEX <u>7</u> 6. COLOR OR RACE <u>W</u> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH <u>1/6/86</u> 9. AGE (in years last birthday) <u>75</u> yrs. 10. IF UNDER 1 YEAR Months <u>6</u> Days <u>14</u> 11. IF UNDER 24 HRS. Hours <u>6</u> Min. <u>14</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Merrifield, Virginia</u> 12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>JAMES W Robey</u>		14. MOTHER'S MAIDEN NAME <u>Kidwell</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> 16. SOCIAL SECURITY NO. <u>NONE</u> 17. INFORMANT <u>John B. + J. Herbert Duvall - (Sons)</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Respiratory Failure</u> DUE TO <u>Uremia</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>Multiple Myeloma</u> DUE TO (c) <u>Multiple Myeloma</u>		INTERVAL BETWEEN ONSET AND DEATH <u>6 hrs</u> <u>5 days</u> <u>2 yrs</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year <u>19</u> Hour a.m. <u>13</u> p.m. <u>19</u>		20d. INJURY OCCURRED <u>White</u> <input type="checkbox"/> <u>Not White</u> <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>1320</u>	
20f. (City or town) <u>Washington</u> (County) <u>D.C.</u> (State) <u>D.C.</u>		21. I certify that (I) (this hospital) attended the deceased from <u>November 1959</u> to <u>July 20, 1961</u> , that (I) (we) last saw the deceased alive on <u>July 20, 1961</u> , and that death occurred at <u>1:30</u> P.M. from the causes and on the date stated above.		22a. SIGNATURE <u>Frank Jagers MD</u> 22b. DATE SIGNED <u>7/21/61</u>	
22c. PHYSICIAN'S NAME (Type) <u>FRANK JAGGERS MD</u>		22d. ADDRESS <u>5707 WISCONSIN AVE</u>		22e. SIGNATURE <u>Cheryl Chase</u>	
23a. BURIAL, CREMATION, OR REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>July 24, 1961</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Mt. Zion</u>	
23d. LOCATION (City, town or county) <u>Bethesda</u>		23e. (State) <u>Maryland</u>		24. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey</u> ADDRESS <u>Bethesda, Maryland</u>	
25a. REC'D BY REGISTRAR <u>4 JUL 24 '61</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Thomas</u>			

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

8167

08160

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Olney</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X Olney</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Brooke Grove Foundation</u>				d. STREET ADDRESS <u>1</u>			
3. NAME OF DECEASED (Type or print) First <u>Mary</u> Middle <u>V</u> Last <u>East</u>				4. DATE OF DEATH Month <u>July</u> Day <u>13</u> Year <u>1961</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept. 1 - 1892</u>	9. AGE (in years last birthday) <u>68</u> yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>		11. BIRTHPLACE (State or foreign country) <u>New Market - Md.</u>		12. CITIZEN OF WHAT COUNTRY <u>USA</u>	
13. FATHER'S NAME <u>Linwood Hammond</u>				14. MOTHER'S MAIDEN NAME <u>Jessie Wood</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>—</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>—</u>		17. INFORMANT <u>Hosp. Records</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Sub Arachnoid Hemorrhage</u> <u>443X</u> DUE TO (b) <u>Hyper tensive cardiac vascular</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>Shen</u>						INTERVAL BETWEEN ONSET AND DEATH <u>24 hrs</u> <u>10 days</u>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part or Part II of item 18)					
20c. TIME OF INJURY Month. Day. Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>July 18</u> 19 <u>56</u> to <u>13 July</u> 19 <u>61</u> and that death occurred at <u>2:00 PM</u> from the causes and on the date stated above.							
22a. SIGNATURE <u>John B. Ziegler</u> M.D.				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>12:10 PM</u> <u>13 July 61</u>	
22c. PHYSICIAN'S NAME (Type) <u>JOHN B. ZIEGLER</u>				22d. ADDRESS <u>OKNE -</u> <u>MBU</u>			
23a. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>7/17/61</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Waynesboro</u>		23d. LOCATION (City, town, or county) (State) <u>Waynesboro Virginia</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Francis H. Barber</u>				ADDRESS <u>Laytonsville, Md.</u>		25a. REC'D BY REGISTRAR <u>JUL 21 '61</u>	
				25b. REGISTRAR'S SIGNATURE <u>Charles L. Knaus</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 may be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 may be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH

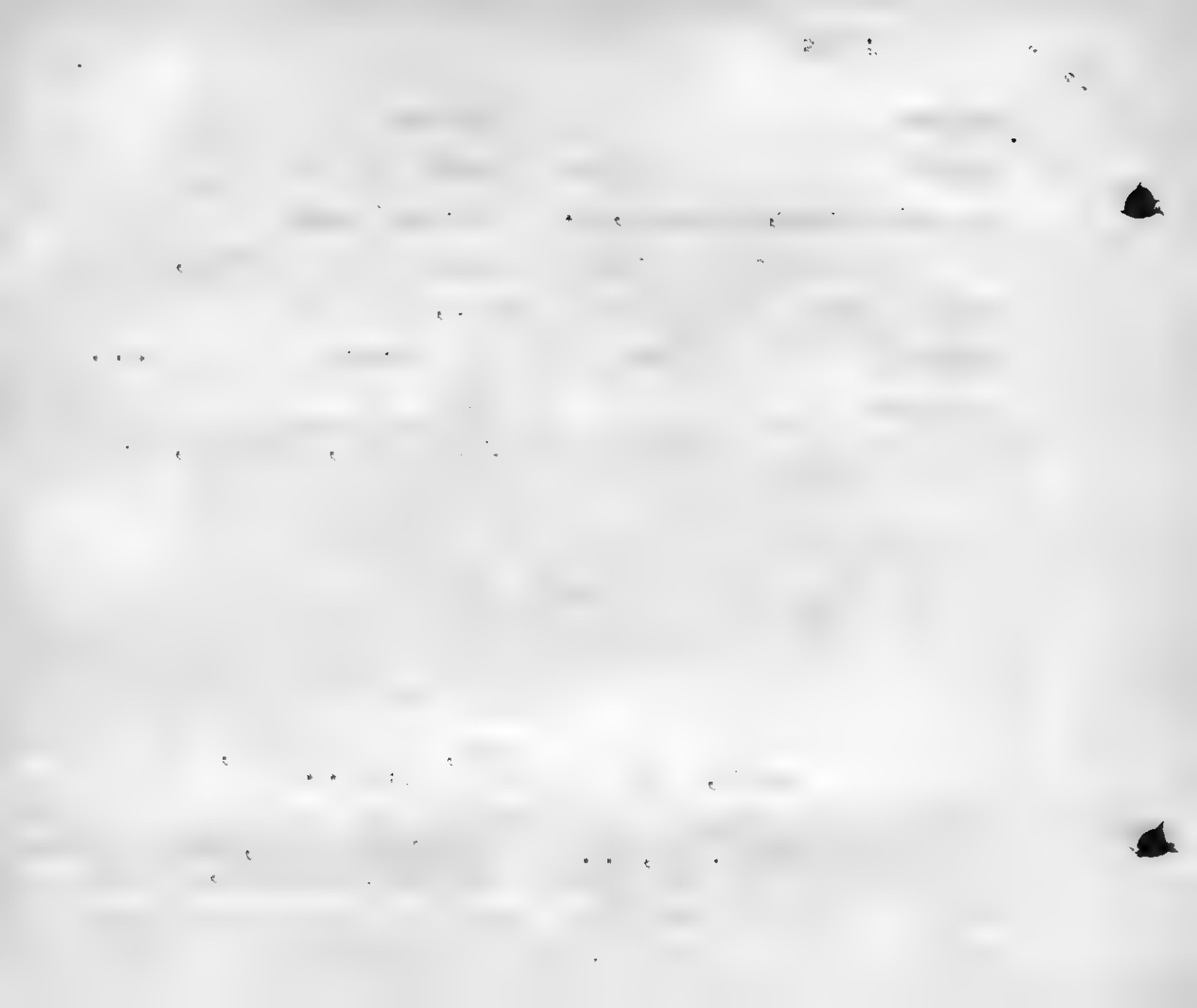
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

8168

08161

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Bethesda c. LENGTH OF STAY IN 1b 15 days d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) The Clinical Center, Bethesda 14, Md.		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) STATE New Jersey b. COUNTY Summit c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) 106 Glenside Avenue d. STREET ADDRESS 677-2	
3. NAME OF DECEASED (Type or print) Paula Josefa Evers		4. DATE OF DEATH July 11, 1961	
5. SEX Female		6. COLOR OR RACE White	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH July 15, 1902	
9. AGE (in years last birthday) 58 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		11. BIRTHPLACE (County & State, or foreign country) Germany	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Joseph Damm	
14. MOTHER'S MAIDEN NAME Unknown		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No	
16. SOCIAL SECURITY NO. Unavailable		17. INFORMATION The Medical Record address The Clinical Center, Bethesda 14, Maryland	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) Cardiac arrhythmia 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last } (b) Congestive heart failure (c) Arteriosclerotic heart disease Rheumatoid Arthritis		INTERVAL BETWEEN ONSET AND DEATH 5 minutes 3 years 3 years	
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Rheumatoid Arthritis	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) <input type="checkbox"/>	
20c. TIME OF INJURY Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) June 26, 1961 to July 11, 1961		20f. (City or town) (County) (State) Summit, New Jersey	
21. I certify that (I) (this hospital) attended the deceased from June 26, 1961 to July 11, 1961 , that (I) (we) last saw the deceased alive on July 11, 1961 , and that death occurred at 9:20 P.M. from the causes and on the date stated above.		22a. SIGNATURE Thomas R. Cate M.D. 22b. ADDRESS The Clinical Center, National Institutes of Health, Bethesda 14, Maryland	
22c. PHYSICIAN'S NAME (Type) THOMAS R. CATE, M.D.		22d. DATE SIGNED 7/12/61	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 7/14/61	
23c. NAME OF CEMETERY OR CREMATORY St. Teresa Cemetery		23d. LOCATION (City, town or county) (State) Summit, New Jersey	
24. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey ADDRESS Bethesda, Maryland		25a. REC'D BY REGISTRAR JUL 13 '61	
25b. REGISTRAR'S SIGNATURE Arthur S. Huns			



12
FOR STATE
HEALTH DEPT.
TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any further action is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

Items 10-21 from 292 MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
8169
MEDICAL EXAMINER'S CERTIFICATE OF DEATH 08162

1. PLACE OF DEATH
COUNTY Montgomery MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Takoma Park
c. LENGTH OF STAY IN lb DOA
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Washington Sanitarium and Hospital
2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission)
a. STATE Maryland b. COUNTY Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring
d. STREET ADDRESS 1714 Dublin Drive
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) Margaret L. Fairfay
4. DATE OF DEATH July 24 1961
5. SEX Female 6. COLOR OR RACE white 7. MARRIED ☒ NEVER MARRIED ☐ 8. DATE OF BIRTH 1-20-32 9. AGE (In years last birthday) 29 yrs. IF UNDER 1 YEAR IF UNDER 24 HRS
Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife 10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) Maryland 12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Charles Crum 14. MOTHER'S MAIDEN NAME Ruth Albright
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) No 16. SOCIAL SECURITY NO. Mr. Stanley Fairfay 17. INFORMANT 1714 Dublin Ave., Silver Spring, Md.
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Asphyxia
983X DUE TO
Conditions, if any, which gave rise to immediate cause (b) Strangulation
(c), stating the underlying cause last. DUE TO
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING CAUSE OF DEATH. 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Undetermined
20c. TIME OF INJURY Month, Day, Year 7-24-1961 20d. INJURY OCCURRED While at work ☐ Not While at work ☒ 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) home 20f. (City or town) Silver Spring (County) Montg. (State) Md.

21 I certify that I took charge of the remains described above, held an Autopsy ☒ Inspection ☐ Inquiry ☐ and in my opinion death resulted from: Natural causes ☐ Accident ☐ Suicide ☐ Homicide ☒ Undetermined manner ☐

CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☐ DATE SIGNED 7-24-61
DEPUTY MEDICAL EXAMINER ☒
ACTUAL SIGNATURE Frank J. Broeschant M.D. EXAMINER'S NAME (Type) FRANK J. BROESCHANT
Address (Street, city, town, or county) 254 Carroll St NW D.C.
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial 22b. DATE THEREOF July 27, 1961 22c. NAME OF CEMETERY OR CREMATORY Arlington National Cemetery 22d. LOCATION (City, town, or country) Arlington (State) Virginia
23. FUNERAL DIRECTOR Gertrude Walters 24a. REC'D BY REG STRA 27 '61 24b. REGISTRAR'S SIGNATURE Arthur S. Hines



1
FOR STATE
HEALTH DEPT.

TO DEPT. OF MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 9, 60

8170
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00163

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u> c. LENGTH OF STAY IN It <u>DOA</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Washington Sanitarium Hosp. 712 Hudson Ave</u>				2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission on) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u> d. STREET ADDRESS			
3. NAME OF DECEASED (Type or print) <u>Irene Frances Farrell</u>				4. DATE OF DEATH Month <u>7</u> Day <u>4</u> Year <u>1961</u>			
5. SEX <u>W</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH <u>8-23-04</u>	
9. AGE (In years, month, day) <u>56</u> yrs. <u>10</u> months <u>11</u> days		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Roll Clerk for Dept of Justice (Va)</u>		11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Elbert E Caldwell</u>				14. MOTHER'S MAIDEN NAME <u>Anthia Belle</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO. <u>?</u>			
17. INFORMANT <u>Mrs. Jean J. Farrell</u>				Address <u>712 Hudson Ave</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> 420.1 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) } DUE TO (c) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town, (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from. Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
SIGNATURE <u>Frank J. Brosch</u> EXAMINER'S NAME (Type)				CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county) <u>7-4-61</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF <u>7/8/1961</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Liberty Mountain Memorial</u>		22d. LOCATION (City, town, or county) (State) <u>Charleston West Va</u>	
23. FUNERAL DIRECTOR <u>Martin W. Young</u>				24a. REC'D BY REGISTRAR <u>1300-N. St. N.W.</u> DATE <u>JUL 6 '61</u> 24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hume</u>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 may be retained by the hospital or attending physician. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

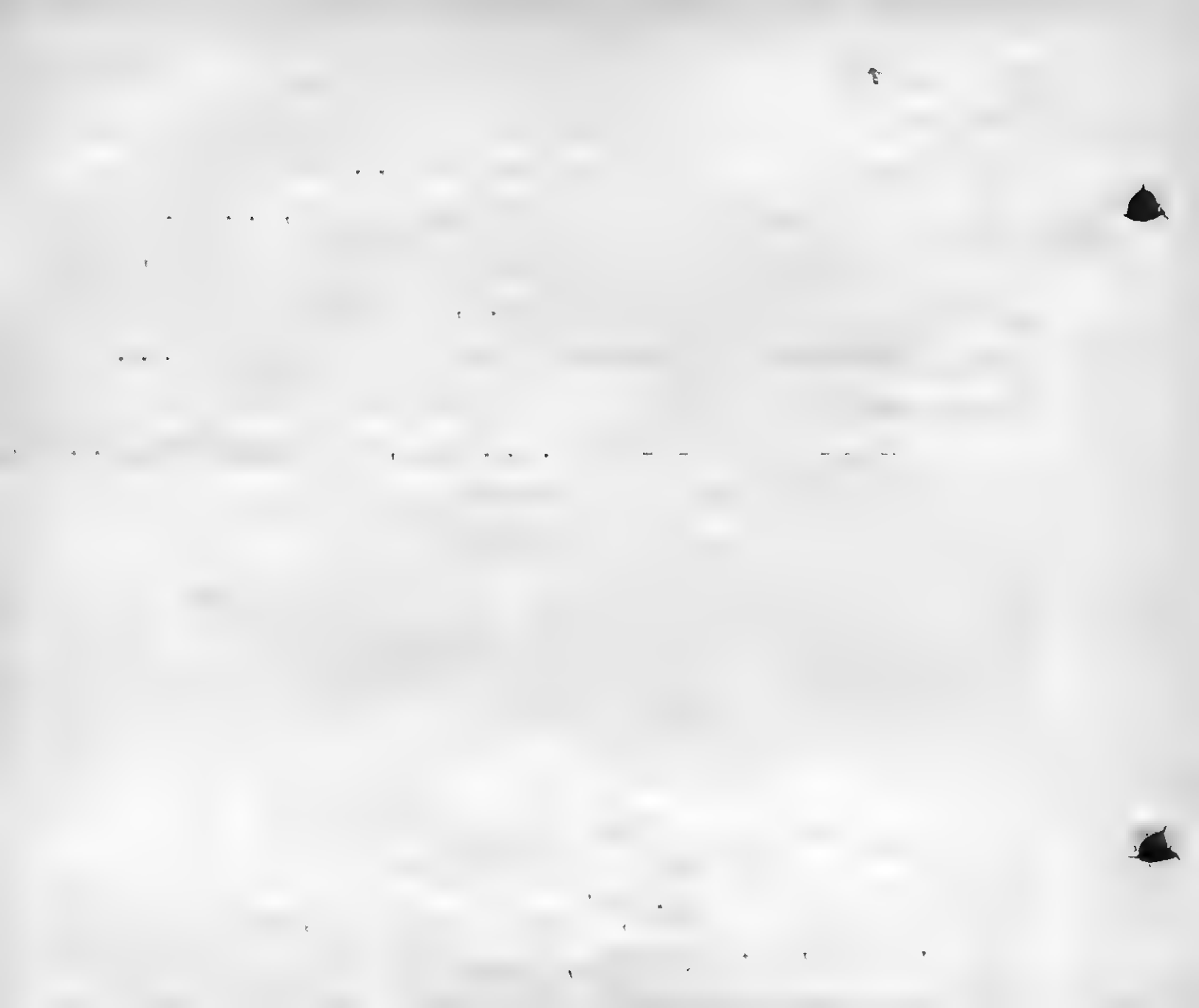
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

8171

02164

1. PLACE OF DEATH a. COUNTY Montgomery		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington D.C. c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 4-2X-3	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring		c. LENGTH OF STAY IN 1b 5-6 years	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Seymour Nursing Home		d. STREET ADDRESS 5610 Colorado Avenue, N.W. Apt. 106	
3. NAME OF DECEASED (Type or print) Veronica Fitzgerald		4. DATE OF DEATH July 24, 1961	
5. SEX Female		6. COLOR OR RACE White	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Sept. 8, 1884	
9. AGE (In years last birthday) 76 yrs.		10. IF UNDER 1 YEAR Months 10 Days 16	
11. IF UNDER 24 HRS. Hours 10 Min. 16		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Tavern Owner (Retired)		10b. KIND OF BUSINESS OR INDUSTRY Self employed	
11. BIRTHPLACE (County & State, or foreign country) Mounds		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Daniel Fitzgerald		14. MOTHER'S MAIDEN NAME Margaret Powers	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 334-30-1138	
17. INFORMANT Mrs. M.R. Strong		Address 5610 Colorado Avenue, N.W. Apt. 106	
18. CAUSE OF DEATH (Enter on y one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage 331X DUE TO Conditions, if any, which gave rise to immediate cause (b) arterio-sclerosis (e), stating the underlying cause last. DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) with no - traumatic head trauma			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Hour a.m. 19 Month, Day, Year p.m.			
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from 3/1/59 to 7/24/61 , that (I) <input checked="" type="checkbox"/> last saw the deceased alive on 7/24/61 , and that death occurred at 7/24/61 , from the causes and on the date stated above.			
22a. SIGNATURE Heiner G. O'Keefe			
22b. DATE SIGNED			
22c. PHYSICIAN'S NAME (Type) Heiner G. O'Keefe			
22d. ADDRESS 5410 - Cedar Hill Ave			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial-Transit 7/28/61			
23b. DATE THEREOF			
23c. NAME OF CEMETERY OR CREMATORY St. Mary's Mounds, Illinois Cemetery			
23d. LOCATION (City, town or county) (State) Mounds, Illinois			
24. FUNERAL DIRECTOR'S SIGNATURE Raymond A. Ziska			
25a. REC'D BY REGISTRAR JUL 26 '61			
25b. REGISTRAR'S SIGNATURE Charles S. Kline			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

8172

08165

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>MONTGOMERY</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>OLNEY</u>				c. LENGTH OF STAY IN 1b <u>3 HRS.</u>			
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X GAITHERSBURG</u>				d. STREET ADDRESS <u>1 Rt. 2</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>MONTGOMERY GENERAL HOSPITAL</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>CORA</u> Middle <u>DAYTON</u> Last <u>MAY FITZWATER</u>				4. DATE OF DEATH Month <u>JUL</u> Day <u>9</u> Year <u>19 61</u>			
5. SEX <u>FEMALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>10/17/1900</u>	
9. AGE (In years last birthday) <u>60</u> yrs		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>		IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>		11. BIRTHPLACE (State or foreign country) <u>VIRGINIA</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>							
13. FATHER'S NAME <u>BENJAMIN FRANK MAY</u>				14. MOTHER'S MAIDEN NAME <u>AMANDA SEE</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>				16. SOCIAL SECURITY NO. <u>—</u>		17. INFORMANT <u>HOSPITAL RECORDS, OLNEY, MD.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>HEMORRHAGE OF PONS Bilateral</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>HYPERTENSIVE HEART DISEASE</u> DUE TO (c) <u> </u>				INTERVAL BETWEEN ONSET AND DEATH <u> </u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) <u> </u>			
20c. TIME OF INJURY Month. Day. Year Hour a. m. p. m. <u> </u> <u> </u> <u>19</u>				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>	
20f. (City or town) <u> </u>				20g. (County) <u> </u>		20h. (State) <u> </u>	
21. I certify that (I) (this hospital) attended the deceased from <u>May 1959</u> to <u>July 9, 1961</u> , that (I) (we) last saw the deceased alive on <u>July 6, 1961</u> , and that death occurred <u>10 P.M.</u> from the causes and on the date stated above.							
22a. SIGNATURE <u>Jack Schumacher</u>				M.D. ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22b. DATE SIGNED <u>7-11-61</u>	
22c. PHYSICIAN'S NAME (Type) <u>J. SCHUMACHER, M. D.</u>				22d. ADDRESS <u>GAITHERSBURG, MD.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>7-12-61</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Valley View</u>		23d. LOCATION (City, town, or county) (State) <u>Nokesville, Virginia</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Frankie L. Barber</u>				ADDRESS <u>Lortonville, Md.</u>		25a. REC'D BY REGISTRAR DATE <u>JUL 13 '61</u>	
25b. REGISTRAR'S SIGNATURE <u>Arthur L. Hines</u>							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

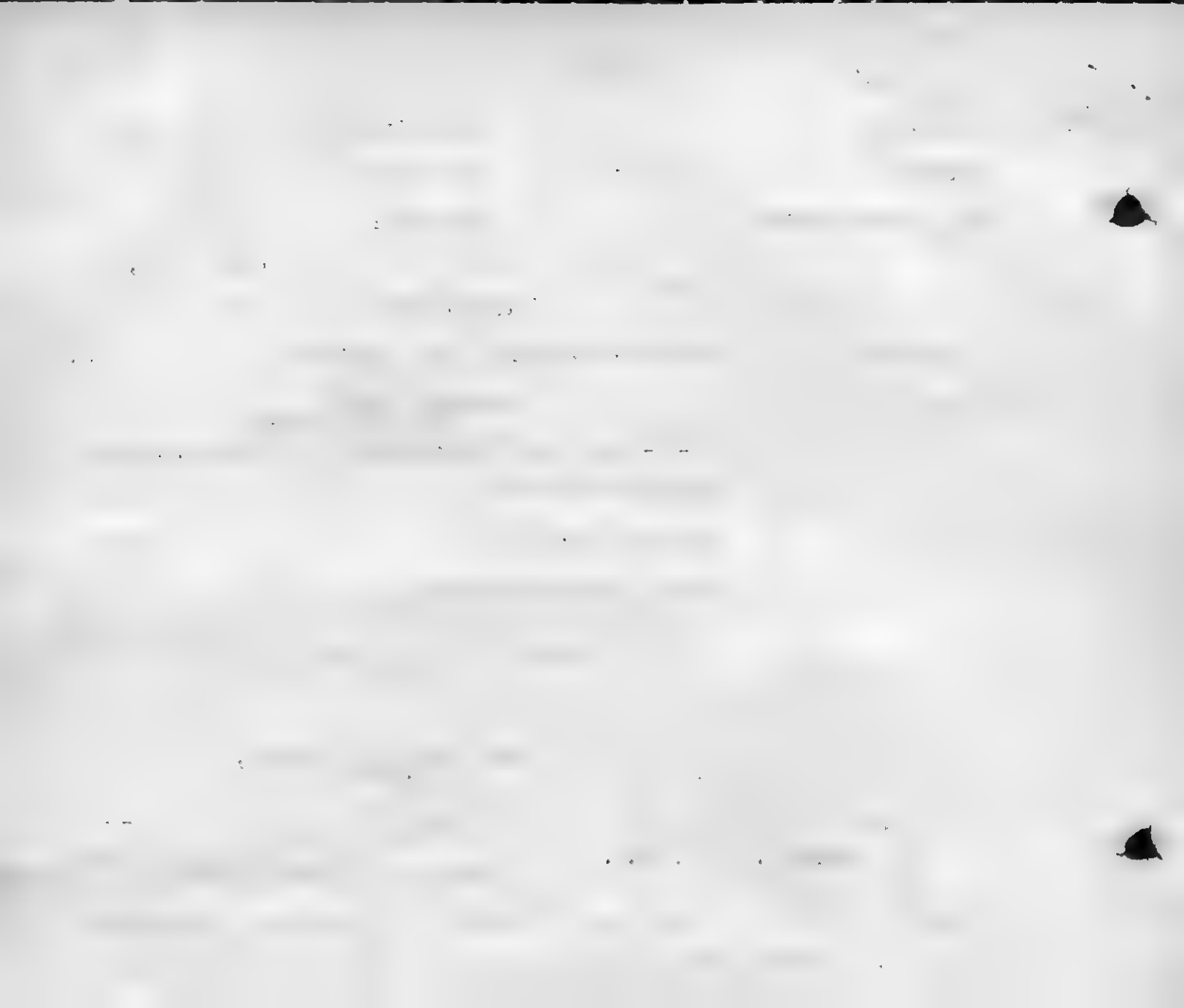
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

8173

08166

1. PLACE OF DEATH a. COUNTY Montgomery		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN 1b 22 Days		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE West Virginia		b. COUNTY Marion		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fairview		d. STREET ADDRESS Route # 2		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) RAY THOMAS FORTNEY		First Middle Last		4. DATE OF DEATH July 5, 1961		5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 4 January 1904		9. AGE (In years last birthday) 57 yrs.		10. F UNDER 1 YEAR Months Days Hours Min		11. BIRTHPLACE (County & State, or foreign country) West Virginia		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME George Fortney		14. MOTHER'S MAIDEN NAME Katherine Jones		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) No		16. SOCIAL SECURITY NO. 236-03-6674		17. INFORMANT The Medical Record		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Subdural Hemorrhage Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, Thrombocytopenia Chronic Myelocytic Leukemia PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 4 Years		INTERVAL BETWEEN ONSET AND DEATH days Months 4 Years		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER):		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)		20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) June 13, 1961 to July 5, 1961		(County)		(State)							
21. I certify that (I) (this hospital) attended the deceased from June 13, 1961 to July 5, 1961 , that (I) (we) last saw the deceased alive on July 5, 1961 , and that death occurred at 11:42am , from the causes and on the date stated above		22a. SIGNATURE Martin J. Cline		22b. DATE SIGNED 7-5-61		22c. PHYSICIAN'S NAME (Type) MARTIN J. CLINE, M.D.		22d. ADDRESS The Clinical Center, National Institutes of Health, Bethesda 14, Maryland		22e. REC'D BY REGISTRAR JUL 7 '61		22f. REGISTRAR'S SIGNATURE William S. Haines									
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 7/8/61		23c. NAME OF CEMETERY OR CREMATORY Fairview Cemetery		23d. LOCATION (City, town or county) Fairview, West Virginia		23e. (State)													
24. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey, Bethesda, Maryland		ADDRESS		25. REC'D BY REGISTRAR JUL 7 '61		25b. REGISTRAR'S SIGNATURE William S. Haines															



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 2 and 4 may be retained by the hospital or attending physician. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
ISM 9/60

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

2174

08167

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u> c. LENGTH OF STAY IN TB <u>5 wks.</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Washington Sanitarium & Hospital</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>District of Columbia</u> COUNTY <u>4</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>4101 Arkansas Ave</u> c. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Brantley Vernon Frank</u>		4. DATE OF DEATH <u>July 20 1961</u>	
5. SEX <u>male</u>		6. COLOR OR RACE <u>white</u>	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>November 5, 1901</u>	
9. AGE (In years, last birthday) <u>59</u> yrs.		10. IF UNDER 1 YEAR: Months <u>5</u> Days <u>17</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Automotive Engineer, Bureau of Aeronautics</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME (Theodore) <u>Shellman Frank</u>	
14. MOTHER'S NAME <u>Suzanna Carrick</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Year, no. or unknown) (If yes give war or dates of service) <u>NO</u>	
16. SOCIAL SECURITY NO. <u>705-05-6649</u>		17. INFORMANT <u>Hospital Records</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Pulmonary Embolism, right</u> Due to (b) <u>Systemic Steroid Insufficiency</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>Chronic Asthma</u> Due to (d) <u>Pulmonary Emphysema & Fibrosis</u>		INTERVAL BETWEEN DEATH AND EXAMINATION <u>3 yrs</u> <u>6 yrs</u> <u>5 yrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY: Hour <u>a.m.</u> Month, Day, Year <u>May 12 1953</u>		20d. INJURY OCCURRED: White <input type="checkbox"/> Not White <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>54 Ellsworth Dr Silver Spring Md</u>		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>May 12 1953</u> to <u>July 20 1961</u> , that (I) (we) last saw the deceased alive on <u>July 20 1961</u> , and that death occurred at <u>5 AM</u> from the causes and on the date stated above.		22a. SIGNATURE <u>Kenneth F. Laughlin</u>	
22b. DATE SIGNED <u>July 20 1961</u>		22c. PHYSICIAN'S NAME (Type) <u>Kenneth F. Laughlin</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>7-25-61 ASSUMPTION</u>		23b. NAME OF CEMETERY OR CREMATORY <u>PECKS KILL N.Y.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Joseph Lawler's Sons Washington D.C.</u>		25. REC'D BY REGISTRAR <u>Arthur E. Harris</u>	
25b. REGISTRAR'S SIGNATURE		26. REGISTRAR'S SIGNATURE	

TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR AIS (4)
15M 9/59

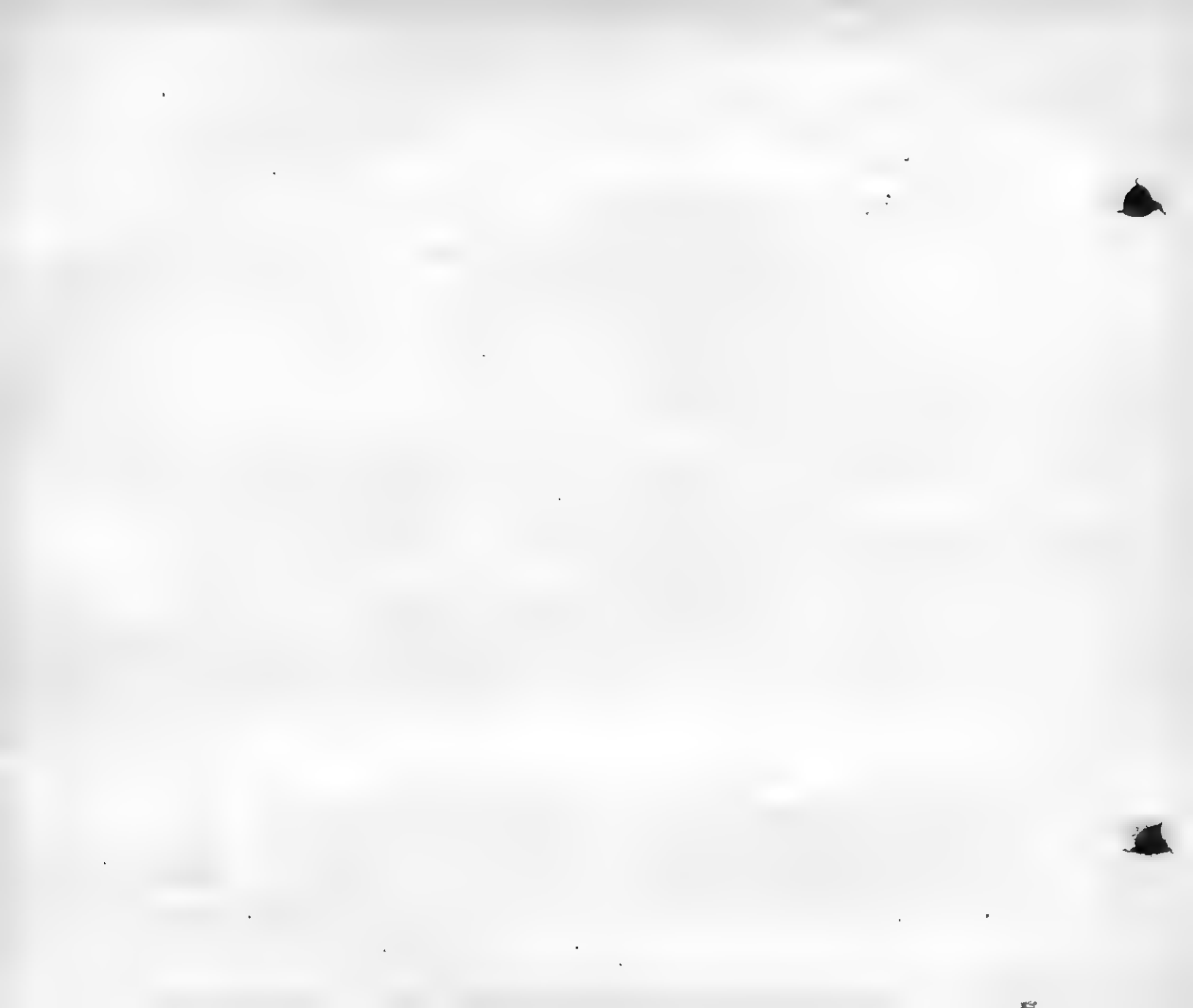
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

8175

02163

1 PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Kensington</u>		c. LENGTH OF STAY IN 1b <u>1 yr 2 mos.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Kensington Gardens Sanatorium</u>		d. STREET ADDRESS <u>1712 Dartmouth Avenue</u>	
3 NAME OF DECEASED (Type or print) First <u>FLORENCE</u> Middle <u>A.</u> Last <u>FREEBURGER</u>		4 DATE OF DEATH Month <u>July</u> Day <u>1</u> Year <u>1961</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>August 1875</u>
9. AGE (In years, months, days, hours, minutes) <u>85</u> yrs		10. IF UNDER 1 YEAR IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>	
11. BIRTHPLACE (State or foreign country) <u>Baltimore, Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Frederick H. Jenkins</u>		14. MOTHER'S MAIDEN NAME <u>Matilda Riddle</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO <u>(If yes, give war or dates of service)</u>	
17. INFORMANT <u>Elmer L. Freeburger (same as #2)</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic Heart Disease</u>			
420.0 DUE TO			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Generalized Arteriosclerosis</u>			
(c) _____			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>1954.12.19</u> to <u>July 1</u> , 1961, that (I) (we) last saw the deceased alive on <u>6/30</u> , 1961, and that death occurred at <u>6 A.</u> M., from the causes and on the date stated above			
22a. SIGNATURE <u>J. Marion Bankhead</u> M.D.		22b. DATE SIGNED <u>7/1/61</u>	
22c. PHYSICIAN'S NAME (Type) <u>J. Marion Bankhead</u>		22d. ADDRESS <u>9241 Col. Blvd. Silver Spring, Md</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF <u>July 3, 1961</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Fort Lincoln Cemetery</u>	23d. LOCATION (City, town, or county) (State) <u>Prince Georges County, Md.</u>
24. FUNERAL DIRECTOR'S SIGNATURE <u>J. Arthur Walters</u> ADDRESS <u>254 Coppock St NW/20</u>		25a. REC'D BY REG. STRAR <u>JUL 3 '61</u> DATE	
25b. REGISTRAR'S SIGNATURE <u>Charles S. Thomas</u>			

MEDICAL CERTIFICATION



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

8176

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

08169

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institutional: Residence before admission) a. STATE <i>Md.</i> b. COUNTY <i>Montgomery</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Takoma Park</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Tak. Park</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>120 Grant Ave.</i>		d. STREET ADDRESS <i>120 Grant Ave</i>	
3. NAME OF DECEASED (Type or print) <i>ANNIE ELIZABETH FRIEDER</i>		4. DATE OF DEATH <i>JULY 2 1961</i>	
5. SEX <i>F</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>6/19/1885</i>
9. AGE (In years last birthday) <i>76</i> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>—</i>	
11. BIRTHPLACE (State or foreign country) <i>Richmond, Va.</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>JOHN KING</i>		14. MOTHER'S MAIDEN NAME <i>?</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <i>None</i>	
17. INFORMANT <i>Mrs Marie Wilhoit</i>		Address <i>215 Spring Ave Takoma Park Md</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Metastatic Carcinoma</i> <i>199X</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>None</i>			INTERVAL BETWEEN ONSET AND DEATH <i>4 years</i>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <i>July 2 1960</i> , to <i>present</i> , 19 <i>1961</i> , that I last saw the deceased alive on <i>July 2 1961</i> , and that death occurred at <i>11:30 P.M.</i> from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>John W Winkler Jr</i>		DATE SIGNED <i>7/2/61</i>	
PHYSICIAN'S NAME (Type) <i>WINKLER, JOHN W</i>		<i>HYATTSVILLE Md.</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF <i>July 5, 1961</i>	22c. NAME OF CEMETERY OR CREMATORY <i>Gate Of Heaven Cemetery</i>	22d. LOCATION (City, town, or county) (State) <i>Montgomery County Md.</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>J. Arthur Walter</i>		24b. REGISTRAR'S SIGNATURE <i>William S. Hanks</i>	
ADDRESS <i>254 Carroll PL NW</i>		DATE <i>JUL 5 '61</i>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Payment may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

117
M

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda c. LENGTH OF STAY IN 1b 6 days d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) The Clinical Center, Bethesda 14, Md.		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Montgomery c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rockville d. STREET ADDRESS 1406 Bernard Place	
3. NAME OF DECEASED (Type or print) Mark Anthony Gallud		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
5. SEX Male		6. COLOR OR RACE White	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>		8. DATE OF BIRTH December 31, 1959	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Child		10b. KIND OF BUSINESS OR INDUSTRY None	
11. BIRTHPLACE District of Columbia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Hans G. Gallud		14. MOTHER'S MAIDEN NAME Elfrid Eggen	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT The Medical Record		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 355X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO Respiratory Arrest Coronary Arrest Medullary Compression	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 10 min 11 hr 12 hr		INTERVAL BETWEEN ONSET AND DEATH 10 min 11 hr 12 hr	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from July 15, 1961 to July 21, 1961 that (I) (we) last saw the deceased alive on July 21, 1961 and that death occurred at 1:15 a.m. from the causes and on the date stated above.			
22a. SIGNATURE James D. Prokop		22b. DATE SIGNED 7/21/61	
22c. PHYSICIAN'S NAME (Type) JAMES D. PROKOP, MD		22d. The Clinical Center, National Institutes of Health, Bethesda 14, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 7/24/61	
23c. NAME OF CEMETERY OR CREMATORY Parklawn		23d. LOCATION (City, town or county) (State) Rockville, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE Wheeler Funeral Home- 1331 E. Montg. Ave. Rockville, Maryland		25a. REC'D BY REGISTRAR JUL 24 '61	
25b. REGISTRAR'S SIGNATURE Caroline L. Thomas			

1
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any of the following are necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH									
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
MEDICAL EXAMINER'S CERTIFICATE OF DEATH									
1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>md</u> b. COUNTY <u>mmty</u>				
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Rensselaer</u>			c. LENGTH OF STAY IN <u>3 yrs</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>36 Rensselaer</u>				
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>3410 Murchison Rd</u>					d. STREET ADDRESS <u>3410 Murchison Rd</u>				
3. NAME OF DECEASED (Type or print) <u>Maurice Allan Glick</u>					4. DATE OF DEATH <u>July 21 1961</u>				
5. SEX <u>Male</u>		6. COLOR <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH <u>5-8-1907</u>		9. AGE (in years, last birthday) <u>54</u> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Plumber</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>retired</u>		11. BIRTHPLACE (State or foreign country) <u>D.C.</u>			12. CITIZEN OF WHAT COUNTRY? <u>41-S.C.</u>		
13. FATHER'S NAME <u>UNKNOWN</u>					14. MOTHER'S MAIDEN NAME <u>IDA V. WISE</u>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>					16. SOCIAL SECURITY NO. <u>212 16 5198</u>				
17. INFORMANT <u>Mrs. John C. Hawse</u>					Address <u>RT #2 Clarksburg, Md.</u>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)									
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cornary sclerosis</u>									
DUE TO (b) <u>420.1</u>									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>Sudden</u>									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)									
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>			20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE <u>Frank J. Bruschan</u> M.D.					CHIEF MEDICAL EXAMINER <input type="checkbox"/>				
EXAMINER'S NAME (Type) <u>FRANK J. BRUSCHAN</u>					ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>				
					DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				
					Address (Street, city, town, or county) <u>7-21-61</u>				
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>XXXX</u>		22b. DATE THEREOF <u>JULY 24, 1961</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Monocacy Cemetery</u>		22d. LOCATION (City, town, or country) (State) <u>Montgomery Md.</u>			
23. FUNERAL DIRECTOR <u>WARNER E. PUMPHRY INC.</u>				24a. REC'D BY REGISTRAR <u>JUL 25 '61</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hawk</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be retained by the hospital or attending physician. Page 3 may be retained by the attending physician and completely filled in by the funeral director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

8179

Item 9 Film G-91

08172

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Bethesda c. LENGTH OF STAY IN b. 17 days d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) The Clinical Center, Bethesda 14, Md.		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Montgomery c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Silver Spring d. STREET ADDRESS 25 East Wayne Avenue e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Catherine Stella Golden		4. DATE OF DEATH July 15 19 61	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1906 January 12, 1905 AGE (In years last birthday) 55 1/2 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY None	11. BIRTHPLACE (County & State, or foreign country) Pennsylvania
13. FATHER'S NAME John McAleese		14. MOTHER'S MAIDEN NAME Mary M. Whalen	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT The Medical Record		17. INFORMANT The Clinical Center, Bethesda 14, Maryland	
18. CAUSE OF DEATH [Enter on y one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiovascular Failure DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 148X (b) Staphylococcal Pneumonia DUE TO (c) Carcinoma Of Post Pharynx		INTERVAL BETWEEN ONSET AND DEATH 14 Days 8 Months	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour 19 m. p.m. Month, Day, Year 19 61	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from June 28 , 19 61 to July 15 , 19 61 , that (I) (we) last saw the deceased alive on July 15 , 19 61 , and that death occurred at 1:10PM from the causes and on the date stated above.			
22a. SIGNATURE Thorne S. Winter, III		22b. DATE SIGNED 7-15-61	
22c. PHYSICIAN'S NAME (Type) Thorne S. Winter, III M.D.		22d. ADDRESS The Clinical Center, National Institutes of Health, Bethesda 14, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Transit-Burial	23b. DATE THEREOF 7/19/61	23c. NAME OF CEMETERY OR CREMATORY New Cathedral Cemetery	23d. LOCATION (City, town or county) (State) Philadelphia, Pennsylvania
24. FUNERAL DIRECTOR'S SIGNATURE Warner E. Rumbrey		25. REC'D BY REGISTRAR June 19 61	
ADDRESS 8434 Georgia Avenue Silver Spring, Maryland		25b. REGISTRAR'S SIGNATURE Arthur S. Hume	

VS. A15ME
BM 7/S9

MEDICAL CERTIFICATION

С. П. Павлов

TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death. Page 4
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

8181

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

08174

1 PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE Maryland b. COUNTY Annarundel	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Olney	c. LENGTH OF STAY IN Tb 1 1/2 hrs.	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glen Burnie	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Montgomery General		d. STREET ADDRESS 703 Stewart Avenue	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3 NAME OF DECEASED (Type or print) First Middle Last Floyd Fleming Graham		4. DATE OF DEATH Month Day Year July 30 19 61	
5 SEX M	6. COLOR OR RACE White	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH 12/28/06
9 AGE (In years last birthday) 54 yrs		IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Teacher		10b. KIND OF BUSINESS OR INDUSTRY	11 BIRTHPLACE (State or foreign country) Penn.
12 CITIZEN OF WHAT COUNTRY? United States			
13. FATHER'S NAME Allen (NMN) Graham		14. MOTHER'S MAIDEN NAME Sarah (NMN) Holler	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service) UNKNOWN		16. SOCIAL SECURITY NO. unknown	
17. INFORMANT Mrs. Joan May Dove		Address Brooms Island, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Myocardial Infarction 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 1 1/2 hrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day Year Hour o m p m. 19 7/29 12:58 PM		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office, bldg., etc.)		20f. (City or town) (County) (State)	
21 I certify that (i) (this hospital) attended the deceased from 7/29 19 61 , to 7/30 19 61 , that (i) two lost saw the deceased alive on 7/30 19 61 , and that death occurred on 7/30 19 61 from the causes and on the date stated above.			
22a. SIGNATURE John P. Martin MD		22b. ADDRESS SANDY SPRING, Md.	
22c. PHYSICIAN'S NAME (Type or print) JOHN P. MARTIN, MD		22d. ADDRESS SANDY SPRING, Md.	
23a. BURIAL, CREMATION REMOVAL (Specify) Burial		23b. DATE THEREOF 3rd Aug. 1961	
23c. NAME OF CEMETERY OR CREMATORY Penn Lincoln Mem. Cem.		23d. LOCATION (City, town, or county) (State) Allegheny Co., Pennsylvania	
24 FUNERAL DIRECTOR'S SIGNATURE R. V. Singleton		25a. REC'D BY REGISTRAR Aug 1 '61	
ADDRESS Glen Burnie, Md.		25b. REGISTRAR'S SIGNATURE Arthur S. Kraus	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be retained by the hospital or attending physician. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

8182

08175

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural) c. LENGTH OF STAY IN b 98 days d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Naval Hospital		2. USUAL RESIDENCE (Where deceased lived, If institutions: Residence before admission) a. STATE MARYLAND b. COUNTY District of Columbia c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington d. STREET ADDRESS 230 Nicholson St. N. E.	
3. NAME OF DECEASED (Type or print) Sesinando		4. DATE OF DEATH July 11 1961	
5. SEX Male	6. COLOR OR RACE Malayan	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> B. DATE OF BIRTH 7-25-08	9. AGE (In years last birthday) 52 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) U. S. Navy		11. BIRTHPLACE (County & State, or foreign country) Manila, P.I.	
13. FATHER'S NAME Pio GUADAMOR		12. CITIZEN OF WHAT COUNTRY? USA	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes WWII		16. SOCIAL SECURITY NO 113-22-2558	
17. INFORMANT (W) Mrs. Marie G. Guadamor		Address Same as # 2 above	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 16-X Carcinoma lung, metastatic DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a). INTERVAL BETWEEN ONSET AND DEATH 6 yrs.			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURED (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year 19 20d. INJURY OCCURED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) 21. I certify that X (this hospital) attended the deceased from April 4 19 61 to July 11 19 61 that X (we) last saw the deceased alive on July 11 19 61 and that death occurred at 7:32PM from the causes and on the date stated above.			
22a. SIGNATURE J. E. STITCHER, LT MC USN		22b. DATE SIGNED 7-12-61	
22c. PHYSICIAN'S NAME (Type) J. E. STITCHER, LT MC USN		22d. ADDRESS U. S. Naval Hospital, Bethesda, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF July 14, 1961	
23c. NAME OF CEMETERY OR CREMATORY Arlington National		23d. LOCATION (City, town or county) (State) Arlington Virginia	
24. FUNERAL DIRECTOR'S SIGNATURE Huntmann Funeral Home, 5732 Georgia Ave., NW,		25a. REC'D BY REGISTRAR JUL 14 '61	
25b. REGISTRAR'S SIGNATURE Arthur S. Piana			

1
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
8183 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02175

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>			
c. LENGTH OF STAY IN 1b <u>4 yrs</u>				d. STREET ADDRESS <u>12215 Kemp Mill Rd</u>			
3. NAME OF DECEASED (Type or print) <u>Harry</u> First <u>Gudelsky</u> Middle <u>Gudelsky</u> Last <u>Gudelsky</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
5. SEX <u>Male</u>				6. COLOR OR RACE <u>White</u>			
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				8. DATE OF BIRTH <u>6-28-'01</u>			
9. AGE (in years last birthday) <u>60</u> yrs.				10. DATE OF DEATH <u>July 16</u> 19 <u>61</u>			
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>Abraham Gudelsky</u>				14. MOTHER'S MAIDEN NAME <u>Ida Halpert</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>				16. SOCIAL SECURITY NO. <u>UNKNOWN</u>			
17. INFORMANT <u>Henry Gudelsky</u>				Address <u>215 Brewster Ave Silver Spring Md</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (b) _____ (c), stating the underlying cause last. DUE TO (c) _____							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I. (a) _____							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>							
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) _____							
20c. TIME OF INJURY Hour <u>19</u> e.m. p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>Frank J. Broschiant</u>				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>FRANK J. Broschiant</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>				22b. DATE THEREOF <u>7-18-61</u>			
22c. NAME OF CEMETERY OR CREMATORY <u>OHEL YAKOV CEMETERY</u>				22d. LOCATION (City, town, or country) <u>BALTIMORE</u> (State) <u>MD.</u>			
23. FUNERAL DIRECTOR <u>Bernard Danzansky</u>				24a. REC'D BY REGISTRAR <u>Sons-3501-14th</u>			
24b. REGISTRAR'S SIGNATURE <u>Clifton L. Thomas</u>				DATE <u>JUL 19 '61</u>			

UNITED STATES DEPARTMENT OF HEALTH
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chevy Chase</u>	
c. LENGTH OF STAY IN 1b <u>13 Days</u>		d. STREET ADDRESS <u>Falstone</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>(Wallie)</u> First <u>Wallburg</u> Middle <u>Yvonne</u> Last <u>Haggard</u>		4. DATE OF DEATH Month <u>July</u> Day <u>9</u> Year <u>1961</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>March 21, 1901</u>
9. AGE (In years last birthday) <u>60</u> yrs.		IF UNDER 1 YEAR: Months <u>6</u> Days <u>10</u> Hours <u>00</u> Min. <u>00</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Homemaker</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Flint Hill, Missouri</u>	
11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Albert Lutz</u>		14. MOTHER'S MAIDEN NAME <u>Elizabeth (?)</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u>No</u> (If yes, give war or dates of service) <u>-</u>		16. SOCIAL SECURITY NO <u>None</u>	
17. INFORMANT <u>Hollis Haggard</u> (Husband)		Address <u>As above</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>anoxia</u> DUE TO <u>MIUX</u> Conditions if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>metastatic carcinoma lungs</u> DUE TO <u>carcinoma left breast</u> (c) <u>1 yr</u>		INTERVAL BETWEEN ONSET AND DEATH <u>1 week</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/></u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Nov 1960</u> to <u>7-9</u> 19 <u>61</u> , that (I) (we) last saw the deceased alive on <u>7-8</u> 19 <u>61</u> , and that death occurred at <u>4 PM</u> , from the causes and on the date stated above.			
22a. SIGNATURE <u>John O. Robben</u> M.D.		22b. DATE SIGNED <u>7/9/61</u>	
22c. PHYSICIAN'S NAME (Type) <u>John O. Robben MD</u>		22d. ADDRESS <u>1015 Spring St Silver Spring Md.</u>	
23a. BURIAL CREMATION REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>7/12/61</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Parklawn Cemetery</u>	
23d. LOCATION (City, town, or county) (State) <u>Rockville, Maryland</u>		24. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumfrey</u> ADDRESS <u>Bethesda, Maryland</u>	
25a. REC'D BY REGISTRAR <u>JUL 11 '61</u>		25b. REGISTRAR'S SIGNATURE <u>William S. Funn</u>	



TO HOSPITAL: The low requires that the death certificate be executed within 24 hours after death. Page 4
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
ISM 9/59

1
8185
MONTGOMERY
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH
CS173

1 PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived if institut an: Res dence before adm-ssion) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>				c. LENGTH OF STAY IN TB <u>2 hours</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u> <u>22</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban Hospital</u>				d. STREET ADDRESS <u>1204 Norman Drive</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3 NAME OF DECEASED (Type or print) First <u>Stanley</u> Middle <u>Evans</u> Last <u>Haney</u>				4. DATE OF DEATH Month <u>July</u> Day <u>27</u> Year <u>1961</u>					
5 SEX <u>M</u>		6 COLOR OR RACE <u>W</u>		7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8 DATE OF BIRTH <u>July 30, 1900</u>			
9. AGE (In years last birthday) <u>60</u> yrs		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min <u> </u>		IF UNDER 24 HRS Hours <u> </u> Min <u> </u>					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Real Estate & Builder</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Real Estate</u>		11. BIRTHPLACE (State or foreign country) <u>Washington, D.C.</u>			
12 CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>									
13 FATHER'S NAME <u>William H. Haney</u>				14. MOTHER'S MAIDEN NAME <u>Molly Howard</u>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no, or unknown) (If yes, give war or dates of service) <u>No</u>				16. SOCIAL SECURITY NO. <u>577-12-3659</u>		17 INFORMANT (Wife) <u>Ethel C. Haney</u> Address <u>as above</u>			
18 CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Respiratory failure</u> <u>45-01</u> DUE TO <u>Shock</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last } (b) <u>Coronary infarct</u> (c) <u> </u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c) <u> </u>								INTERVAL BETWEEN ONSET AND DEATH <u>Minutes</u> <u>hrs</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u> </u> p. m. <u> </u> 19 <u> </u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town) (County) (State)									
21 I certify that (I) (this hospital) attended the deceased from <u>7-24</u> , 19 <u>61</u> , to <u> </u> , 19 <u> </u> , that (I) (we) last saw the deceased alive on <u> </u> , 19 <u> </u> , and that death occurred at <u> </u> M, from the causes and on the date stated above.									
22a. SIGNATURE <u>Richard P. Delaney</u>				M.D. ATTENDING PHYS <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22b. DATE SIGNED <u>7-27-61</u>			
22c. PHYSICIAN'S NAME (Type) <u>Richard P. Delaney</u>				22d. ADDRESS <u>1323 Harvard St., Silver Spring, Md.</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>7/27/61</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Parklawn Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>Montgomery Maryland</u>			
24. FUNERAL DIRECTOR'S SIGNATURE <u>Harner E. Humphrey, Inc.</u>				25a. REC'D BY REGISTRAR <u>Jul 26 '61</u>		25b. REGISTRAR'S SIGNATURE <u>Richard E. Kinney</u>			
ADDRESS <u>8434 Georgia Avenue</u> <u>Silver Spring, Maryland</u>									

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1, 2, and 3 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u> c. LENGTH OF STAY IN b. <u>2 days</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Washington Jan + Hosp</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>DC</u> b. COUNTY _____ c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u> d. STREET ADDRESS <u>6918 Willow St</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>R. ta Maude Harrison</u> First Last Middle 5. SEX <u>female</u> 6. COLOR OR RACE <u>white</u> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>2-29-96</u> 9. AGE (In years last birthday) <u>65</u> yrs. 10. BIRTHPLACE (County & State, or foreign country) <u>W. Virginia</u> 11. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
12. FATHER'S NAME <u>Harvey W. Jack</u> 13. MOTHER'S MAIDEN NAME <u>Maude Mosher.</u>		14. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> 15. SOCIAL SECURITY NO. _____ 16. INFORMANT <u>Son - old Records</u> Address _____	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>600000</u> DUE TO <u>Chronic Pyelitis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) _____ 20c. TIME OF INJURY Month, Day, Year <u>July 1961</u> Hour a.m. _____ p.m. _____ 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____ 20f. (City or town) _____ (County) _____ (State) _____			
21. I certify that (I) (this hospital) attended the deceased from <u>July 1955</u> to <u>July 25, 1961</u> , that (I) (two) last saw the deceased alive on <u>July 25, 1961</u> , and that death occurred at <u>1:25 P.M.</u> from the causes and on the date stated above			
22a. SIGNATURE <u>James M. Whitlock M.D.</u> 22c. PHYSICIAN'S NAME (Type) <u>JAMES M. WHITLOCK</u>		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22d. ADDRESS <u>7717 Carroll Ave Takoma Park Md.</u> 22b. DATE SIGNED <u>7-25-61</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> 23b. DATE THEREOF <u>July 28, 1961</u> 23c. NAME OF CEMETERY OR CREMATORY <u>Washington National Cemetery</u> 23d. LOCATION (City, town or county) <u>Suitland</u> (State) <u>Maryland</u>		24. FUNERAL DIRECTOR'S SIGNATURE <u>Arthur S. Thomas</u> ADDRESS <u>254 Carroll St. NW.</u> 25a. READ BY REGISTRAR <u>JBL 27 '61</u> 25b. REGISTRAR'S SIGNATURE <u>Arthur S. Thomas</u>	

(M)

(I)

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
SM 7/59

FOR STATE
HEALTH DEPT.

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Item 9 & 14 Film G-200 7/10/61

28180

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>TAKOMA PARK</u> c. LENGTH OF STAY IN 1b <u>D.O.A.</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>WASHINGTON SANITARY HOSPITAL</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>PRINCE GEORGE</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>TAKOMA PARK</u> d. STREET ADDRESS <u>429 Boyd Avenue</u>	
3. NAME OF DECEASED (Type or print) <u>JOHN</u> First Middle Last <u>JOSEPH HARTEY</u>		4. DATE OF DEATH <u>7-2-1961</u> Month Day Year	
5. SEX <u>MALE</u> 6. COLOR OR RACE <u>CAUC</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> W. DOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH <u>NOV 2-1893</u> Month Day Year		9. AGE (In years if UNDER 1 YEAR, IF UNDER 24 HRS. rest birthd. Months Days Hours Min.) <u>67</u> yrs	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>TRAFFIC MGR.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>CARLOADING</u>	
11. BIRTHPLACE (State or foreign country) <u>NEW YORK</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>THOMAS FRANCIS HARTEY</u>		14. MOTHER'S MAIDEN NAME <u>JENNIE</u> unknown	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <u>Yes W.W.I.</u>		16. SOCIAL SECURITY NO. <u>161-03-6798</u>	
17. INFORMANT <u>Mrs. Elizabeth T. Hartey (same as #2)</u> Address		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cornary occlusion</u> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>420.1</u> (c) <u>420.1</u> DUE TO cause last.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL CONDITION GIVEN IN PART I (e)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20b. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20c. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20d. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from. Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Frank J. Broschart</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>FRANK J. Broschart</u>		ASS STANT MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>July 2, 1961</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Union National Cemetery</u>		22d. LOCATION (City, town, or country) (State) <u>Uglington</u>	
23. FUNERAL DIRECTOR <u>William R. Rietz</u>		24a. REC'D BY REGISTRAR <u>William R. Rietz</u>	
ADDRESS <u>234 Carroll, 24 W. 11th St.</u>		24b. REGISTRAR'S SIGNATURE <u>William R. Rietz</u>	
DATE <u>JUL 5 '61</u>		DATE <u>JUL 5 '61</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 may be retained by the hospital or attending physician. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Bethesda (Rural) c. LENGTH OF STAY IN it 1 day d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) U. S. Naval Hospital		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Florida b. COUNTY Jacksonville c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 6747 Watoma Street d. STREET ADDRESS 6747 Watoma Street	
3. NAME OF DECEASED (Type or print) Doris First Hawes Middle Hawes Last		4. DATE OF DEATH July 19 Month 19 61 Day 19 61 Year	
5. SEX Female		6. COLOR OR RACE Caucasian	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED		8. DATE OF BIRTH July 21, 1924	
9. AGE (In years last birthday) 36 yrs.		10. IF UNDER 1 YEAR Months 36 Days 36	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Georgia	
11. BIRTHPLACE (County & State, or foreign country) Georgia		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME James R. Vickery		14. MOTHER'S MAIDEN NAME Zora Joniel	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. Percy W. Hawes	
17. INFORMANT Percy W. Hawes		Address Same as # 2 above	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Respiratory obstruction Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Adenocarcinoma, bronchogenic DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office building, etc.) 20f. (City or town) (County) (State)			
21. I certify that (this hospital) attended the deceased from... July 18, 1961 to... July 19, 1961 , that (we) last saw the deceased alive on... July 19, 1961 , and that death occurred at... 11:05 PM , from the causes and on the date stated above.			
22a. SIGNATURE R.W. Mackie 22b. DATE SIGNED July 20, 1961 22c. PHYSICIAN'S NAME (Type) R.W. MACKIE CAPT MC, USN 22d. ADDRESS U. S. Naval Hospital, Bethesda, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial-Shippment 23b. DATE THEREOF 20 July 1961 23c. NAME OF CEMETERY OR CREMATORY Edgewater Cemetery 23d. LOCATION (City, town or county) (State) New Smyrna Florida			
24. FUNERAL DIRECTOR'S SIGNATURE Tyson Wheeler Address Rockville, Md. 25a. REC'D BY REGISTRAR JUL 24 61 25b. REGISTRAR'S SIGNATURE Charles S. Hanna			

TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be retained by the hospital or attending physician
may be retained by the funeral director and completely filled in. The funeral director,
page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with
the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M III/59

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

8189

08182

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>mont.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cherry Chase</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cherry Chase</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>Own Home</u>		d. STREET ADDRESS <u>15407 Wootton Ave.</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Anna</u> Middle <u>Ellis</u> Last <u>Henshaw</u>		4. DATE OF DEATH Month <u>July</u> Day <u>15</u> Year <u>1961</u>	
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Feb 3 1879</u>	
9. AGE (In years) <u>82</u> yrs. 10. IF UNDER 1 YEAR: Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min <u>0</u>		11. IF UNDER 24 HRS: Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min <u>0</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housekeeping</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>	
11. BIRTHPLACE (State or foreign country) <u>Thurmont Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Dr. John J. Henshaw</u>		14. MOTHER'S MAIDEN NAME <u>Margaret Rouger</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes, give year or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Miss Grace Henshaw</u>		Address <u>Cherry Chase 5407 Wootton Ave.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Infarction</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Coronary Arteriosclerosis</u> DUE TO (c) <u>Generalized Arteriosclerosis</u>		INTERVAL BETWEEN ONSET AND DEATH <u>24 hrs.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <u>0</u> a.m. <u>19</u> p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Sept 1936</u> to <u>July 15</u> , 19 <u>61</u> , that (I) (we) last saw the deceased alive on <u>July 15</u> , 19 <u>61</u> , and that death occurred at <u>7:15</u> M., from the causes and on the date stated above.			
22a. SIGNATURE <u>E. Stuart Lyddane</u>		22b. DATE <u>1961</u>	
22c. PHYSICIAN'S NAME (Type) <u>E. Stuart Lyddane</u>		22d. ADDRESS <u>3066 - Laurel - N. C. Ave.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>7-18-61</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>United Brethren Cem.</u>		23d. LOCATION (City town or county) (State) <u>Thurmont, Md. Fred. Cp.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Raymond E. Crager</u>		25a. REC'D BY REGISTRAR <u>JUL 18 '61</u>	
ADDRESS <u>Thurmont, Md.</u>		25b. REGISTRAR'S SIGNATURE <u>Charles L. Thomas</u>	



FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
SM 7/59

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8190

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

28183

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Chevy Chase c. LENGTH OF STAY in 1b MARYLAND d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 3204 Woodbine Street				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Chevy Chase d. STREET ADDRESS 3204 Woodbine Street				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Anna		First Anna		Middle D		Last HITT		4. DATE OF DEATH Month July Day 12 Year 19 61	
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Aug. 31, 1874		9. AGE (in years, if UNDER 1 YEAR, IF UNDER 24 HRS. last birthday) 86 yrs. 10 months 11 days 11 hours 11 min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY - - - - -				11. BIRTHPLACE (State or foreign country) Kentucky	
13. FATHER'S NAME Nichols G. Daub				14. MOTHER'S MAIDEN NAME Caroline ? Daub				12. CITIZEN OF WHAT COUNTRY? USA	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) No				16. SOCIAL SECURITY NO. None				17. INFORMANT Caroline Arnold-Same Item #2-daughter Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 331X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) Respiratory failure DUE TO (c) Cerebral vascular accident				INTERVAL BETWEEN ONSET AND DEATH 36 hours 9 weeks					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I a)									
Fracture of right hip (4 months)									
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a.m. p.m. 19		Month, Day, Year 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> . and in my opinion death resulted from. Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE Frank J. Broschart				CHIEF MEDICAL EXAMINER <input type="checkbox"/>				DATE SIGNED July 12, 1961	
EXAMINER'S NAME (Type) Frank J. Broschart				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Bur-trans.				22b. DATE THEREOF 7/12/1961		22c. NAME OF CEMETERY OR CREMATORY Valley of Rest Cem.		22d. LOCATION (City, town, or country) LaGrange, Kentucky	
23. FUNERAL DIRECTOR Robert A. Pumphrey Bethesda, Maryland				24a. REC'D BY REGISTRAR JUL 13 '61		24b. REGISTRAR'S SIGNATURE Arthur S. Hines			

MEDICAL CERTIFICATION

8191

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

08184

1 PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2 USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Olney		c. LENGTH OF STAY IN TB 2 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Montgomery General Hospital		e. STREET ADDRESS 9453 Holsey Rd.	
3 NAME OF DECEASED (Type or print) First Ethel Middle Mae Last Holsey		4. DATE OF DEATH Month July Day 17 Year 19 61	
5 SEX Female	6 COLOR OR RACE Colored	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH July 26, 1881
9. AGE (In years last birthday) 79 yrs		10. IF UNDER 1 YEAR Months 7 Days 17 Hours 19 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own home	
11 BIRTHPLACE (State or foreign country) Waterford, Va.		12. CITIZEN OF WHAT COUNTRY? USA	
13 FATHER'S NAME Noble Robinson		14. MOTHER'S MAIDEN NAME Emma Robinson	
15 WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. ----	
INFORMANT John H. Holsey,		Address Item 2	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) infarction & gangrene of jejunum & ileum 450 48 hours DUE TO Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. (b) Thrombosis superior mesenteric artery 48 hours DUE TO (c) Arteriosclerosis, generalized many years			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Chronic bronchitis, arteriosclerotic heart disease			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part I of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from July 4 , 19 61 to 7/17/61 , 19 61 , that I lost saw the deceased alive on 7/17/61 , 19 61 , and that death occurred at 8:55 A. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Main Street DATE SIGNED 7/17/61			
ACTUAL SIGNATURE G. F. Meadors M.D.		DATE SIGNED 7/17/61	
PHYSICIAN'S NAME (Type) G. F. MEADORS, MD		Damascus, Maryland	
22a. BURIAL, CREMATION REMOVAL (Specify) Burial	22b. DATE THEREOF 7/20/61	22c. NAME OF CEMETERY OR CREMATORY Friendship Meth.	22d. LOCATION (City, town, or county) (State) Damascus, Md.
23 FUNERAL DIRECTOR'S SIGNATURE Oliver L. Mohorn		24a. REC'D BY REGISTRAR DATE JUL 20 '61	
ADDRESS Damascus, Md.		24b. REGISTRAR'S SIGNATURE Arthur S. Thomas	

TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

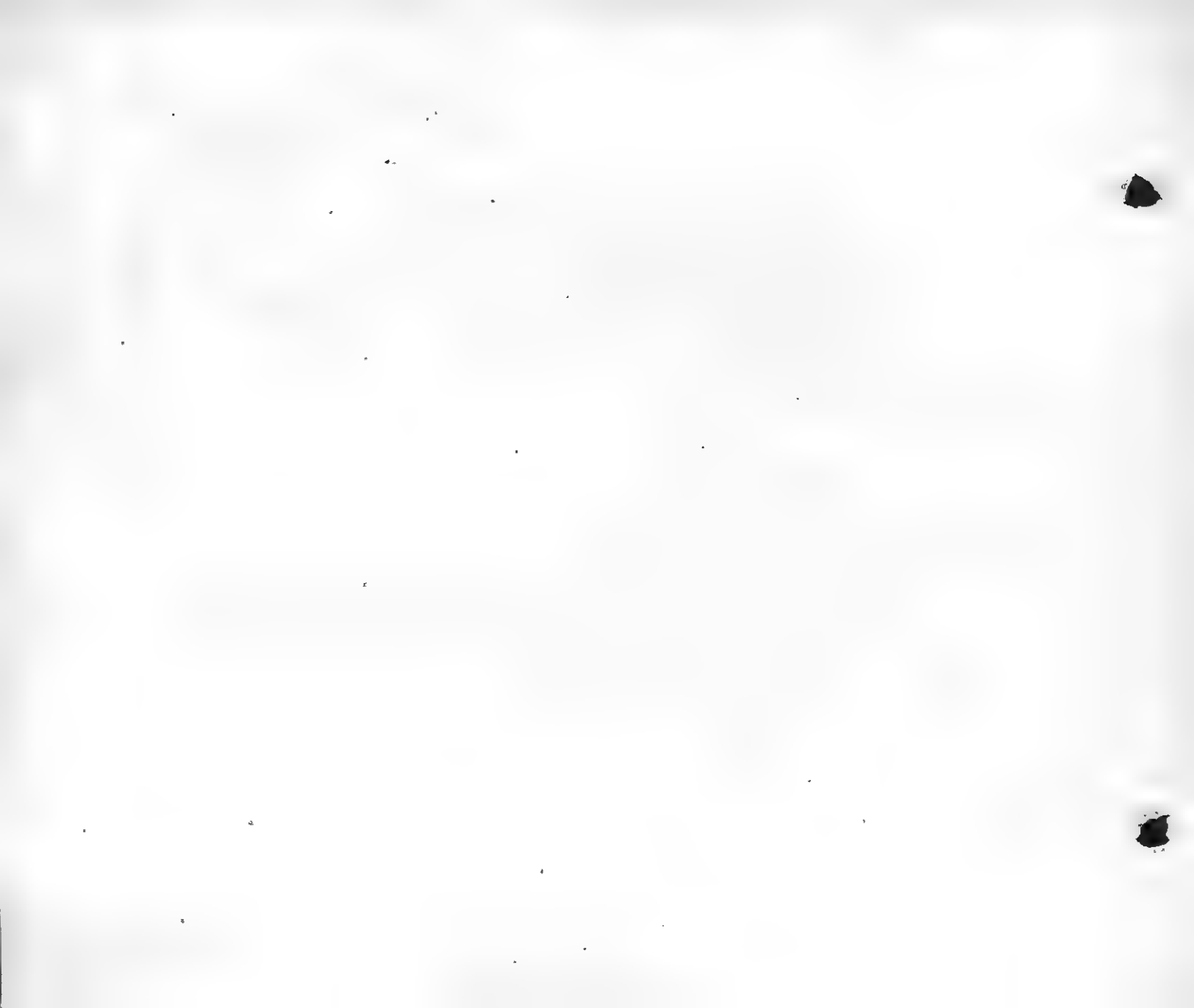
8192

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. 08185

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institut an: Residence before admission) a. STATE <u>Louisiana</u> b. COUNTY <u>Orleans</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda, Md</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>New Orleans</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>4411 Elm Street</u>		d. STREET ADDRESS <u>1423 Louisiana Ave.</u>	
3. NAME OF DECEASED (Type or print) First <u>BERTHA</u> Middle <u>Howell</u> Last <u>Howell</u>		4. DATE OF DEATH Month <u>July</u> Day <u>22</u> Year <u>19 61</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>July 7, 1881</u>
9. AGE (in years last birthday) <u>80</u> yrs		IF UNDER 1 YEAR: Months <u>0</u> Days <u>15</u> Hours <u></u> Min <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u></u>	
11. BIRTHPLACE (State or foreign country) <u>Utilla Spanish Honduras</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA - Naturalized</u>	
13. FATHER'S NAME <u>Nathan Howell</u>		14. MOTHER'S MAIDEN NAME <u>Catherine Morgan</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO <u>None</u>	
17. INFORMANT <u>Daughter</u> Address <u>Lucille Woodville</u>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))	
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>GASTRO-INTESTINAL Bleeding</u>		INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u>	
DUE TO (b) <u>STRESS GASTRIC ULCER - Mesenteric occlusion</u>		<u>1 day</u>	
DUE TO (c) <u>Arteriosclerosis - EMPHYSEMA - Arteriosclerotic Heart Dis.</u>		<u>5-10 Yrs.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month. Day. Year Hour a. m. p. m. 19 <u></u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>6-27</u> , 19 <u>61</u> , to <u>7-22</u> , 19 <u>61</u> (that I last saw the deceased alive on <u>7-22</u> , 19 <u>61</u> and that death occurred at <u>9³⁰</u> A.M., from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>H. L. Tanenbaum, M.D.</u>		ADDRESS (Street, city or town, state) <u>3701- Conn. Ave. NW</u> DATE SIGNED <u>7/22/61</u>	
PHYSICIAN'S NAME (Type) <u>HERBERT L. TANENBAUM</u>		<u>Wash DC</u>	
22a. BURIAL, CREMATION, REMOVA. (Specify) <u>Burial</u>	22b. DATE THEREOF <u>7-24-61</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Mt. Olivet Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>ROBERT A. PUMPHREY</u>		ADDRESS <u>Bethesda, Md.</u>	
24a. REC'D BY REGISTRAR <u>JUL 25 '61</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Frank</u>	



TO HOSPITAL FOR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 may be retained by the hospital or attending physician. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Bethesda (Rural) c. LENGTH OF STAY IN 1b 3 days d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) U. S. Naval Hospital		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE District of Columbia b. COUNTY District of Columbia c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Washington d. STREET ADDRESS 2715 Ordway Street, N.W. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Lucille Edwards HOYT		4. DATE OF DEATH Month July Day 16 Year 1961	
5. SEX Female		6. COLOR OR RACE Caucasian	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH July 20, 1898	
9. AGE (In years last birthday) 62 yrs.		10. IF UNDER 1 YEAR Months 6 Days 16	
11. IF UNDER 24 HRS. Hours 16 Min. 00		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME COOKE		14. MOTHER'S MAIDEN NAME GEORGIANNA EDWARDS	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war and dates of service) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Hospital Records		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute respiratory failure DUE TO Tuberculosis, pulmonary, active, far advanced Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) 60 or more years (c)		INTERVAL BETWEEN ONSET AND DEATH 60 or more years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that XX (this hospital) attended the deceased from July 13 , 19 61 to July 16 , 1961, that XX (we) last saw the deceased alive on July 16 1961, and that death occurred at 12:04 PM from the causes and on the date stated above.			
22a. SIGNATURE F. M. Highly Jr.		22b. DATE SIGNED July 17, 1961	
22c. PHYSICIAN'S NAME (Type) F. M. HIGHLY JR. LT MC USN		22d. ADDRESS U. S. Naval Hospital, Bethesda, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 21 July 1961	
23c. NAME OF CEMETERY OR CREMATORY Arlington National		23d. LOCATION (City, town or county) (State) Arlington, Virginia	
24. FUNERAL DIRECTOR'S SIGNATURE Joseph Gawler's & Son ADDRESS 1756 Penn. Ave. Wash. D.C.		25a. REC'D BY REGISTRAR JUL 19 '61 DATE	
25b. REGISTRAR'S SIGNATURE Arthur S. Thoms			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

8194

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. 08187

1. PLACE OF DEATH a. COUNTY <u>Montgomery, Olney</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Brooke Grove Found 3 Mo 134</u> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Brooke Grove Foundation</u>			2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE <u>Virginia</u> b. COUNTY c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Falls Church</u> d. STREET ADDRESS <u>820 LaBella Walk</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First <u>Joseph</u> Middle <u>Peace</u> Last <u>Hughes</u>			4. DATE OF DEATH Month <u>July</u> Day <u>3</u> Year <u>1961</u>		
5. SEX <u>M</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH <u>4/11/1877</u>		9. AGE (In years last birthday) <u>84</u> yrs		IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Factory Worker</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Retired-</u>		11. BIRTHPLACE (State or foreign country) <u>Tennessee</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			13. FATHER'S NAME <u>Unknown</u>		
14. MOTHER'S MAIDEN NAME <u>Unknown</u>			15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u>No</u>		
16. SOCIAL SECURITY NO. <u>411-01-4586</u>			17. INFORMANT <u>Mrs. Ester Simson</u> Address <u>213-5114 Fairfax Co. Welfare</u>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Probable Myocardial infarction</u> DUE TO <u>Arteriosclerotic Cardiovascular disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>20</u> DUE TO (c)					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		20g. (County)		20h. (State)	
21. I certify that I attended the deceased from <u>4/20</u> , 19 <u>61</u> , to <u>7/3</u> , 19 <u>61</u> , that I last saw the deceased alive on <u>5/8</u> , 19 <u>61</u> , and that death occurred at <u>9:00</u> A.M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Sandy Spring, Md</u> DATE SIGNED <u>7/3/61</u>					
ACTUAL SIGNATURE <u>John P. Martin</u>					
PHYSICIAN'S NAME (Type) <u>JOHN P. MARTIN, MD.</u> <u>Sandy Spring, Maryland</u>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Bur-Transit</u>		22b. DATE THEREOF <u>7/7/61</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Forest Hills Cem.</u>	
22d. LOCATION (City, town, or county) <u>Chattanooga, Tennessee</u>		22e. (State)			
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey</u> ADDRESS <u>Bethesda, Maryland</u>					
24a. REC'D BY REGISTRAR <u>DATE JUL 6 '61</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kimes</u>			

(M)

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

8195

33185

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Washington, D.C.</u> b. COUNTY <u>47 X</u>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Bethesda Maryland</u>				c. LENGTH OF STAY IN TB <u>8 days</u>			
d. NAME OF HOSPITAL (if not in hospital, give street address) <u>Suburban Hospital</u>				d. STREET ADDRESS <u>3825 Livingston St NW</u>			
3. NAME OF DECEASED (Type or print) First <u>Arthur</u> Middle <u>B.</u> Last <u>ILsley</u>				4. DATE OF DEATH Month <u>July</u> Day <u>15</u> Year <u>1961</u>			
5. SEX <u>m</u>		6. COLOR OR RACE <u>w</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>March 29, 1915</u>	
9. AGE (In years, lost birthday) <u>46</u> yrs.		IF UNDER 1 YEAR: Months <u>1</u> Days <u>15</u>		IF UNDER 24 HRS.: Hours <u>15</u> Min. <u>00</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Civil Engineer</u>	
10b. KIND OF BUSINESS OR INDUSTRY <u>U.S. Govt</u>		11. BIRTHPLACE (State or foreign country) <u>Limerick, Ireland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>			
13. FATHER'S NAME <u>Col. Edwin ILsley</u>				14. MOTHER'S MAIDEN NAME <u>Day</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO. <u>214-28-7702</u>		17. INFORMANT <u>Mrs. Maude ILsley</u> Address <u>3825 Livingston St NW DC</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebrovascular accident</u> <u>331X</u> DUE TO <u>Cerebral arteriosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>?</u> DUE TO (c) <u>?</u>							INTERVAL BETWEEN ONSET AND DEATH <u>24 hrs</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>?</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY: Month <u>July</u> , Day <u>15</u> , Year <u>1961</u> Hour <u>11</u> a.m. <u>15</u> p.m.				20d. INJURY OCCURRED: While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>	
20f. (City or town) <u>Washington, D.C.</u> (County) <u>D.C.</u> (State) <u>D.C.</u>				21. I certify that (I) (this hospital) attended the deceased from <u>July 5, 1961</u> to <u>July 15, 1961</u> that (I) (we) last saw the deceased alive on <u>July 15, 1961</u> and that death occurred at <u>5:00</u> M, from the causes and on the date stated above			
22a. SIGNATURE <u>George A. Gray, Jr.</u>				22b. DATE SIGNED <u>7/15/61</u>		22c. PHYSICIAN'S NAME (Type) <u>George A. Gray, Jr. M.D.</u>	
22d. ADDRESS <u>4740 Cherry Chase Drive, Chevy Chase, Md.</u>				23a. BURIAL, CREMATION, or other disposal <u>7/18/61</u>			
23b. DATE THEREOF <u>7/18/61</u>				23c. NAME OF CEMETERY OR CREMATORY <u>Ft. Lincoln Cemetery</u>		23d. LOCATION (City, town, or county) <u>Pr. Geo. Co., Maryland</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>St. James Co</u> ADDRESS <u>Wash, D.C.</u>				25a. REC'D BY REGISTRAR <u>DATE JUL 17 '61</u>		25b. REGISTRAR'S SIGNATURE <u>William S. Thomas</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any of the following are necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 9/60

FOR STATE
HEALTH DEPT.

M

I

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08189

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u>				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>and DC.</u> b. COUNTY <u>and DC.</u>					
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Kensington</u>				c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Washington</u>					
c. LENGTH OF STAY IN 1b <u>5 days</u>				d. STREET ADDRESS <u>1870 Wyoming Ave. NW</u>					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Kensington Garden Nursing Home</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <u>Elizabeth Liggitt Ireland</u>				DATE OF DEATH <u>JULY 28</u> 19 <u>61</u>					
5. SEX <u>Female</u>				6. COLOR OR RACE <u>White</u>					
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>				8. DATE OF BIRTH <u>8-24-1867</u>					
9. AGE (In years last birthday) <u>93</u> yrs.				10. IF UNDER 1 YEAR Months Days 11. IF UNDER 24 HRS. Hours Min.					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>own home</u>					
11. BIRTHPLACE (State or foreign country) <u>Ireland</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.C.</u>					
13. FATHER'S NAME <u>WM H. Liggitt</u>				14. MOTHER'S MAIDEN NAME <u>Rebecca Miller</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <u>NO</u>				16. SOCIAL SECURITY NO. <u>none</u>					
17. INFORMANT <u>Nursing Home Record</u>				Address					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cornary occlusion</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) (c)								INTERVAL BETWEEN ONSET AND DEATH <u>sudden</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I, a) <u>History of previous heart disease</u>								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.								20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>								20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)								20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>								CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
ACTUAL SIGNATURE <u>Frank J. Broschant</u>								M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>FRANK J. Broschant</u>								DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
Address (Street, city, town, or county) <u>7-28-61</u>								DATE SIGNED	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>								22b. DATE THEREOF <u>8/1/61</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Arlington National Cemetery, Arlington, Va.</u>								22d. LOCATION (City, town, or country) (State)	
23. FUNERAL DIRECTOR <u>Warner E. Pumphrey, Inc. 8434 Georgia Ave. S. S., Md.</u>								24a. REC'D BY REGISTRAR 24b. REGISTRAR'S SIGNATURE <u>Arthur L. Thomas</u>	
DATE <u>AUG 2 '61</u>									



TO HOSPITAL BY ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

8397
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

08190

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING	
c. LENGTH OF STAY IN 1b approx. 2 yrs.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 503 - C SOUTHAMPTON DRIVE		d. STREET ADDRESS 503 - C SOUTHAMPTON DRIVE	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last MARY KATHERINE JACKSON		4. DATE OF DEATH Month Day Year JULY 1 19 61	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH DEC. 31, 1882
9. AGE (In years last birthday) yrs 78		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY OWN HOME	
11. BIRTHPLACE (State or foreign country) PENNA.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME ALEXANDER MARKEY		14. MOTHER'S MAIDEN NAME SUSAN F. METZ	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. NONE	
17. INFORMANT MRS. CARL I. SANDERSON, JR. SAME AS 2-D		Address	
18. CAUSE OF DEATH [Enter only one cause pertaining to (a) (b), and (c)] PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Carcinoma Colon & Metastases DUE TO (b) Generalized Metastatic Lesions DUE TO (c) Calhexia - and Dehydration - coma PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Diabetes Mellitus INTERVA. BETWEEN ONSET AND DEATH 2 years 1 1/2 years 3 mos.			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State) Monroeville Pa. 15.78.1m	
21. I certify that (n) (this hospital) attended the deceased from Sept 23 1959 to JUNE 26 1961 that (I) (we) last saw the deceased alive on June 24 1961 and that death occurred at 7:00 p.m. from the causes and on the date stated above			
22a. SIGNATURE Thomas F. Quinn M.D.		22b. DATE SIGNED 7/1/61	
22c. PHYSICIAN'S NAME (Type) THOMAS F. QUINN		22d. ADDRESS 501-B Southampton Dr. Silver Spring	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF JULY 5, 1961	
23c. NAME OF CEMETERY OR CREMATORY OAK GROVE CEMETERY		23d. LOCATION (City, town, or county) (State) UNIONTOWN, FAYETTE CO., PENNA.	
24. FUNERAL DIRECTOR'S SIGNATURE WARNER E. PUMPHREY, INC. SILVER SPRING, MD. Raymond A. Ziska		25a. REC'D BY REGISTRAR JUL 5 '61	
25b. REGISTRAR'S SIGNATURE Charles S. Hume			



TO HOSPITAL: The law requires that the death certificate be completed within 24 hours after death. It may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
8198
CERTIFICATE OF DEATH

08191

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u> c. LENGTH OF STAY (In days) <u>1</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban</u>		2. USUAL RESIDENCE (Where deceased lived, if Institution; Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u> d. STREET ADDRESS <u>1200 1st St</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Tim</u> <u>Joseph</u> <u>J</u>		4. DATE OF DEATH Month Day Year <u>7</u> <u>26</u> <u>1961</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 21, 1911</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Owner - Jacobsen Florist</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Columbia, U.S.A.</u>	
13. FATHER'S NAME <u>John</u>		14. MOTHER'S MAIDEN NAME <u>MARY</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war and dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>Unknown</u>	
17. INFORMANT <u>MARY JO JOHNSON</u> Address <u>Bethesda, Md.</u>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>MYOCARDIAL INFARCTION</u> DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) _____	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. (City or town) (County) (State) <u>Bethesda</u> <u>Montgomery</u> <u>Md.</u>		20f. (City or town) (County) (State) <u>Bethesda</u> <u>Montgomery</u> <u>Md.</u>	
21. I certify that (I) (this hospital) attended the deceased from <u>7/22/61</u> to <u>7/26/61</u> , that (I) (we) last saw the deceased alive on <u>7/26/61</u> , and that death occurred at <u>8:00 PM</u> , from the causes and on the date stated above.			
22a. SIGNATURE <u>A. J. Brennan</u>		22b. DATE SIGNED <u>7/26/61</u>	
22c. PHYSICIAN'S NAME (Type) <u>A. J. Brennan</u>		22d. ADDRESS <u>4630 Montgomery Ave. Bethesda, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>7/29/61</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Prince Georges Maryland</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey</u>		25a. REC'D BY REGISTRAR <u>DAVID J. 31 '61</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles S. Kraus</u>		25c. REGISTRAR'S SIGNATURE <u>Charles S. Kraus</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician, and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1

(M)

1

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

08192

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Bethesda c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 8719 Burning Tree Road		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Bethesda d. STREET ADDRESS 8719 Burning Tree Road		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) John W. JANSSEN		4. DATE OF DEATH July 20 1961		9. AGE (In years last birthday) 70 IF UNDER 1 YEAR Months 4 Days 23 Hours Min. 	
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) School Director		10b. KIND OF BUSINESS OR INDUSTRY Education		11. BIRTHPLACE (County & State or foreign country) Holland	
13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Unknown		12. CITIZEN OF WHAT COUNTRY? Naturalized	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 577-38-9984		17. INFORMANT Elizabeth B. Janssen-Wife-same 2d	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARCINOMA OF STOMACH DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DIA DUE TO (b) DUE TO (c) 		INTERVAL BETWEEN ONSET AND DEATH about 2 yrs			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a.m. 19 p.m. 		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) 		20g. (County) 		20h. (State) 	
21. I certify that (I) (this hospital) attended the deceased from May 1958 to July 20, 1961 , that (I) (we) last saw the deceased alive on July 17, 1961 , and that death occurred at 825 PM , from the causes and on the date stated above.					
22a. SIGNATURE DeWitt E. DeLawter		22b. DATE SIGNED 		22c. PHYSICIAN'S NAME (Type) DeWITT E. DeLawter	
22d. ADDRESS 8025 ABERDEEN Rd, Bethesda Md					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 7/22/61		23c. NAME OF CEMETERY OR CREMATORY Parklawn Cemetery	
23d. LOCATION (City, town or county) Rockville, Maryland		23e. (State) 			
24. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey		24a. ADDRESS Bethesda, Maryland		25a. REC'D BY REGISTRAR JUL 24 '61	
25b. REGISTRAR'S SIGNATURE Clifford L. Evans					

VR A15 (4)
15M 9/60

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any of the following is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

M

I

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH 08193

1. PLACE OF DEATH
COUNTY Montgomery County MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Takoma Park
c. LENGTH OF STAY IN lb 18
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Washington Sanitarium

2. USUAL RESIDENCE (Where deceased lived, if Institution; Residence before admission)
a. STATE Maryland b. COUNTY Montgomery
c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Takoma Park
d. STREET ADDRESS 7409 Carroll Ave

3. NAME OF DECEASED (Type or print) Baby Girl Johnson

4. DATE OF DEATH
Month 7 Day 2 Year 1961

5. SEX Female 6. COLOR OR RACE W 7. MARRIED ☐ NEVER MARRIED ☒ 8. DATE OF BIRTH 7-1-61
WIDOWED ☐ DIVORCED ☐

9. AGE (In years last birthday) 0 yrs. IF UNDER 1 YEAR Months 0 Days 0 IF UNDER 24 HRS. Hours 23 Min. 31

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) — 10b. KIND OF BUSINESS OR INDUSTRY — 11. BIRTHPLACE (State or foreign country) Maryland 12. CITIZEN OF WHAT COUNTRY U.S.A.

13. FATHER'S NAME Lee J. Johnson 14. MOTHER'S MAIDEN NAME Myrtle Sponangle
Address Mothers Hosp Chart.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No 16. SOCIAL SECURITY NO. — 17. INFORMANT Mothers Hosp Chart.

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) 774X Prematurity DUE TO Premature labor
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO Auto accident
(c) Auto accident
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I a Mother involved in auto accident 6-25-61

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☒ OR CONTRIBUTING ☐ CAUSE OF DEATH. Auto accident 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) Auto accident

20c. TIME OF INJURY Hour a.m. 11:15 PM Month, Day, Year 6-25-1961 20d. INJURY OCCURRED While at work ☐ Not While at work ☒ 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) street 20f. (City or town) Amin Park (County) P.G. (State) MD

21. I certify that I took charge of the remains described above, held an Autopsy ☐. Inspection ☒ Inquiry ☒ and in my opinion death resulted from. Natural causes ☐ Accident ☒ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE Frank J. Broschert M.D. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☐ DEPUTY MEDICAL EXAMINER ☒ DATE SIGNED 7-2-61

EXAMINER'S NAME (Type) FRANK J. Broschert Address (Street, city, town, or county) 7-2-61

22a. BURIAL, CREMATION, REMOVAL (Specify) burial 22b. DATE THEREOF July 3-1961 22c. NAME OF CEMETERY OR CREMATORY Green Grove Cemetery, Pikesville, Md 22d. LOCATION (City, town, or county) (State) Pikesville, Md

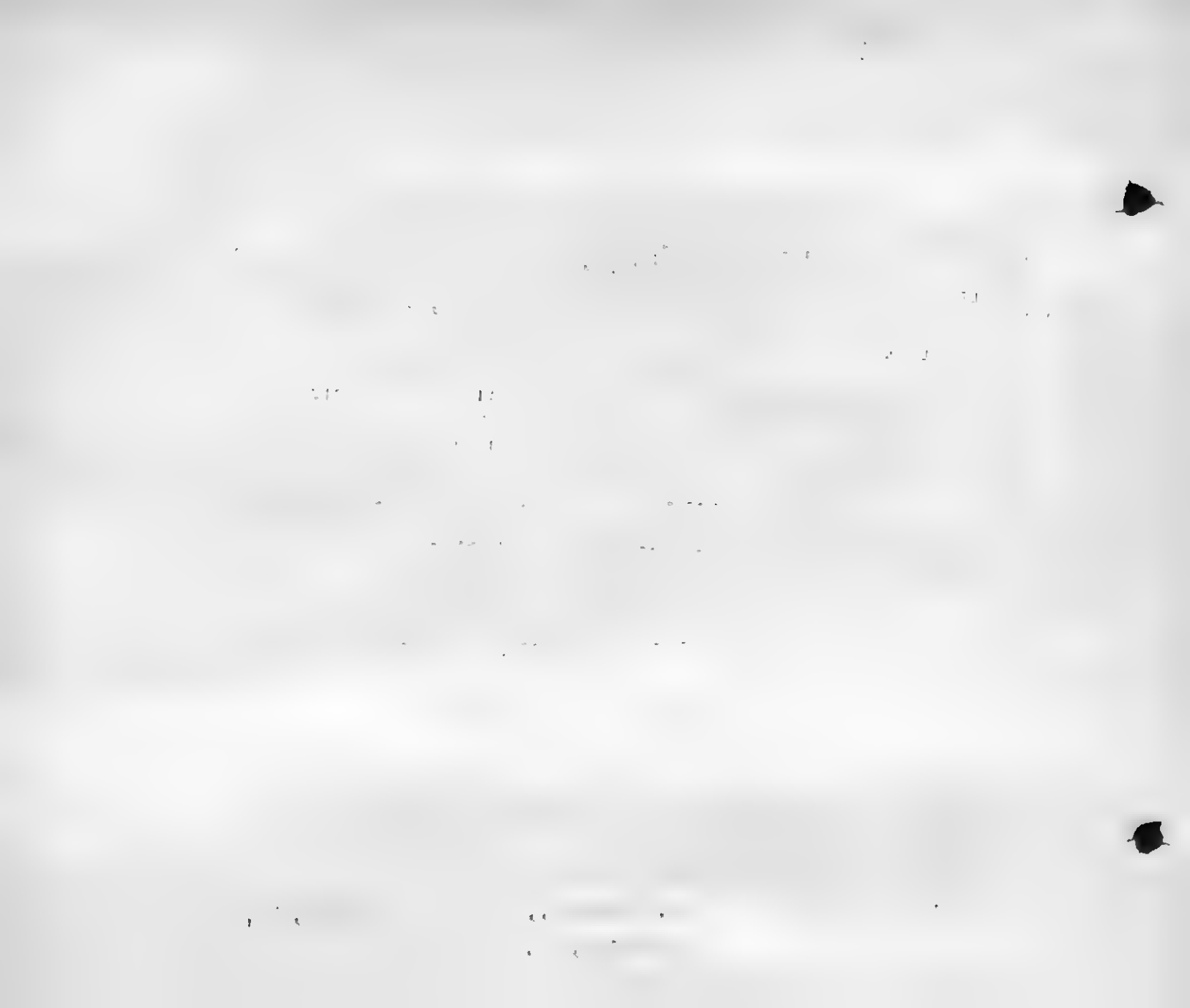
23. FUNERAL DIRECTOR Walter Funeral Home ADDRESS 254 Carroll St. N.E. 24a. RECEIVED BY REGISTRAR JUL 5 '61 24b. REGISTRAR'S SIGNATURE Charles S. Hanna

FOR STATE HEALTH DEPT.

M

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY MONTGOMERY b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) OLNEY c. LENGTH OF STAY IN TB 13 HOURS d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) MONTGOMERY GENERAL HOSPITAL				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ROCKVILLE d. STREET ADDRESS 4105 MUNCASTER MILL ROAD e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) LAWRENCE		First Lawrence Middle Melford Last JOHNSON		4. DATE OF DEATH JULY 5 19 61			
5. SEX MALE		6. COLOR OR RACE NEGRO		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			
8. DATE OF BIRTH JUNE 30, 1916		9. AGE (In years last birthday) 45 yrs.		IF UNDER 1 YEAR: Months 5 Days 19 Hours 61 Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CLERK		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) MARYLAND			
12. CITIZEN OF WHAT COUNTRY? UNITED STATES		13. FATHER'S NAME MILTON JOSEPH JOHNSON		14. MOTHER'S MAIDEN NAME ELIZABETH FRANCIS HAMMOND			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT HOSPITAL RECORDS, OLNEY, MARYLAND			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral hemorrhage & laceration DUE TO (b) Fracture of skull DUE TO (c) Auto accident Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.				INTERVAL BETWEEN ONSET AND DEATH 13 hrs			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Fracture of kidney & spleen - fracture of ribs 12 ribs left							
20a. INTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Passenger in auto involved in accident							
20c. TIME OF INJURY 1:15 p.m.		20d. INJURY OCCURRED 19		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town)		20g. (County)		20h. (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE Frank J. Brosch		EXAMINER'S NAME (Type) FRANK J. BROSCH		CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 7/9/61		22c. NAME OF CEMETERY OR CREMATORY Mt. Pleasant., Rockville, Md.			
22d. LOCATION (City, town, or country) Norbeck, Md.		22e. (State)		22f. DATE 7-6-61			
23. FUNERAL DIRECTOR Robert L. Suwoda		23a. ADDRESS Rockville, Md.		23b. REGISTRAR'S SIGNATURE Clifford S. Hanna			



MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08195

FOR STATE
HEALTH DEPT.

8202

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Johnson Rd</u> c. LENGTH OF STAY IN It <u>1 day</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>R.F. Silva Spring</u>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) e. STATE <u>md</u> f. COUNTY <u>SV</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u> d. STREET ADDRESS <u>1407 Argyle Ave</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
3. NAME OF DECEASED (Type or print) <u>Richard Langston Johnson Jr</u>		4. DATE OF DEATH <u>July 23 1961</u>		5. SEX <u>male</u>		6. COLOR OR RACE <u>col</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWER <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>3-22-1904</u>		9. AGE (in years last birthday) <u>57</u> yrs. IF UNDER 1 YEAR: Months <u>0</u> Days <u>0</u> IF UNDER 24 HRS.: Hours <u>0</u> Min. <u>0</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>movie operator</u>				10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (State or foreign country) <u>md</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME <u>Richard L. Johnson Sr</u>				14. MOTHER'S MAIDEN NAME <u>Flourence E. Howard</u>				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>Sam. Johnson - Steu</u>				16. SOCIAL SECURITY NO. <u>217-07-0348</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> DUE TO <u>20.1</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>20.1</u> DUE TO (c)												INTERVAL BETWEEN ONSET AND DEATH <u>found dead in bed</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a).													
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Hour <u>19</u> a.m. <u>0</u> p.m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from. Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>													
ACTUAL SIGNATURE <u>Frank J. Broschant</u>				CHIEF MEDICAL EXAMINER <input type="checkbox"/>				DATE SIGNED <u>7-23-61</u>					
EXAMINER'S NAME (Type) <u>FRANK J. Broschant</u>				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				Address (Street, city, town, or county) (State)					
22a. BURIAL, CREMATION, REMOVAL. (Specify) <u>Burial</u>				22b. DATE THEREOF <u>7-26-61</u>				22c. NAME OF CEMETERY OR CREMATORY <u>Mt. Auburn Cem</u>				22d. LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u>	
23. FUNERAL DIRECTOR <u>Mr. Frances C. Hendry</u>				ADDRESS <u>518 W. Biddle St.</u>				24a. REC'D BY REGISTRAR <u>JUL 27 '61</u>				24b. REGISTRAR'S SIGNATURE <u>Arthur L. Francis</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE HEALTH DEPT.



1

MEDICAL CERTIFICATION

Items 10-21, 23-29

1. PLACE OF DEATH
a. COUNTY Montgomery MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Silver Spring
c. LENGTH OF STAY IN 1b 12 hrs
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Georgian Motel

2. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)
e. STATE N. J. b. COUNTY _____
c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Jersey City
d. STREET ADDRESS 47 Duncan Ave
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) Irving Bertram Kahn
First Middle Last
4. DATE OF DEATH July 18 1961 Month Day Year
5. SEX male 6. COLOR OR RACE white 7. MARRIED ☒ NEVER MARRIED ☐ 8. DATE OF BIRTH 5-7-1915 9. AGE In years 46 If UNDER 1 YEAR If UNDER 24 HRS.
Months Days Hours Min.
10a. USUA. OCCUPATION (Give kind of work done during most of working life, even if retired) Salesman 10b. KIND OF BUSINESS OR INDUSTRY Mens Clothing 11. BIRTHPLACE (State or foreign country) Maryland 12. CITIZEN OF WHAT COUNTRY? U.S.A

13. FATHER'S NAME Louis Kahn 14. MOTHER'S MAIDEN NAME Sara Hirschman
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) 16. SOCIAL SECURITY NO. 17. INFORMANT Bey. Kahn - 7002 Park Hts. Ave. Balt md Address

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Synergistic poisoning
888.6 DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO
(b) Ethel alcohol 0.12 mg. %
(c) Barbiturates 1.1 mg. %
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I. (a) 19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH. 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Collapsed in motel room where he was spending the night.
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 19 20d. INJURY OCCURRED While at work ☐ Not While at work ☐ 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Motel 20f. (City or town) Silver Spring Mont. (County) Mont. (State) Md.

21. I certify that I took charge of the remains described above, held an Autopsy ☒ Inspection ☐ Inquiry ☐ and in my opinion death resulted from: Natural causes ☐ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☒

ACTUAL SIGNATURE Frank J. Broschert CHIEF MEDICAL EXAMINER ☐
EXAMINER'S NAME (Type) FRANK J. BROSCHEFT M.D. ASSISTANT MEDICAL EXAMINER ☐ DATE SIGNED 7-18-61
DEPUTY MEDICAL EXAMINER ☒ Address (Street, city, town, or county) 2100 Eutaw Place

22a. BURIAL, CREMATION, REMOVAL (Specify) Burial 22b. DATE THEREOF 7-19-61 22c. NAME OF CEMETERY OR CREMATORY Hebrew Friendship 22d. LOCATION (City, town, or country) (State) Baltimore Md

23. FUNERAL DIRECTOR Jack Lewis Inc ADDRESS 2100 Eutaw Place 24. REGISTRY MONITOR JUL 20 1961 DATE JUL 20 1961 24b. REGISTRAR'S SIGNATURE John P. Kean

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

8204

Item 9 Film G292 7/21/61

08197

1 PLACE OF DEATH a. COUNTY <u>Montgomery</u>		2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) STATE <u>Takoma Park Md</u> COUNTY <u>Prince George</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>142</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>6506, 3rd Ave.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>Kensington Gardens 3000 McLean Ave</u>		d. STREET ADDRESS <u>16X-1</u>	
3 NAME OF DECEASED (Type or print) <u>Maucha L Keller</u>		4. DATE OF DEATH Month <u>7</u> Day <u>25</u> Year <u>1961</u>	
5 SEX <u>Female</u>	6 COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>Dec. 11 1883</u>
9 AGE (In years last birthday) <u>77</u> yrs.		10. IF UNDER 1 YEAR Months <u>7</u> Days <u>18</u> Hours <u>0</u> Min <u>0</u>	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housekeeper</u>		10b KIND OF BUSINESS OR INDUSTRY <u>Home</u>	
11 BIRTHPLACE (State or foreign country) <u>Germany</u>		12 CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13 FATHER'S NAME <u>Mr Lederer</u>		14. MOTHER'S MAIDEN NAME <u>Mrs Barbara Lederer</u>	
15 WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <u>Rest Home Records</u>	
17. INFORMANT <u>Rest Home Records</u>		Address	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE: (a) <u>Congestive heart failure</u>		<u>3 hr</u>
(b) <u>Anteriosclerotic cardiovascular disease</u>		<u>5 yrs</u>
(c) <u>lying cause lost.</u>		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c)		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m.	20d INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f (City or town)		(County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>Feb 6</u> 1959, to <u>July 25</u> 1961, that (I) (we) last saw the deceased alive on <u>July 25</u> 1961, and that death occurred at <u>8:15 PM</u> , from the causes and on the date stated above.		
22a SIGNATURE <u>M. F. OTTMAN</u>	M. D. ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22b DATE SIGNED <u>July 25, 1961</u>
22c PHYSICIAN'S NAME (Type) <u>M. F. OTTMAN</u>	22d. ADDRESS <u>401 Kennedy St NW 19c</u>	

23a BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>	23b DATE THEREOF <u>7/28/61</u>	23c NAME OF CEMETERY OR CREMATORY <u>George Washington Cem</u>	23d LOCATION (City, town, or county) (State) <u>Prince Georges County Md.</u>
24 FUNERAL RECORDING <u>W. K. HUNTEMANN & Son</u>		25a REC'D BY REG STRAR DATE <u>JUL 28 '61</u>	25b REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>

TO HOSPITAL: The attending physician: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
15M 9/59

1
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

08193

1 PLACE OF DEATH a COUNTY <i>Montgomery</i> MARYLAND		2 USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <i>Md.</i> b. COUNTY <i>Montgomery</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Chillicothe</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Chillicothe</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Popine Nursing Home</i>		4211 Bradley Lane	
3 NAME OF DECEASED (Type or print) <i>Catherine G. KELLEY</i>		4. DATE OF DEATH Month <i>7</i> Day <i>3</i> Year <i>1961</i>	
5. SEX <i>F</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Oct. 15 1874</i>
9 AGE (In years less birthday) <i>86</i> yrs.		IF UNDER 1 YEAR Months <i>8</i> Days <i>19</i> Hours <i></i> Min <i></i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>CONN.</i>	
11 BIRTHPLACE (State or foreign country) <i>U.S.A.</i>		12 CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>Nickolas Reid</i>		14. MOTHER'S MAIDEN NAME <i>Catherine Coleman</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>no</i>		16. SOCIAL SECURITY NO <i>None</i>	
17 INFORMANT <i>Pro JOS, A CANTREL - 4211 BRADLEY LANE</i>		Address <i>Chillicothe, Md.</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cardiac arrest</i> <i>420.0</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <i>ht failure</i> DUE TO (c) <i>A. S. H. D.</i>			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Hemiplegia due to old CVA</i>			
19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21 I certify that (I) (this hospital) attended the deceased from <i>4/24 1961</i> to <i>7/3 1961</i> that (I) (we) last saw the deceased alive on <i>6/24 1961</i> and that death occurred at <i>8 P.</i> M, from the causes and on the date stated above.			
22a. SIGNATURE <i>Marvin Wadler</i>		22b. DATE SIGNED <i>7/3</i>	
22c. PHYSICIAN'S NAME (Type) <i>MARVIN WADLER M.D.</i>		22d. ADDRESS <i>8218 Wic Ave. S.S., Md.</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Transit-burial</i>		23b. DATE THEREOF <i>7/8/61</i>	
NAME OF CEMETERY OR CREMATORY <i>MT. St. Benedict</i>		23d. LOCATION (City, town, or county) (State) <i>Hartford, Connecticut</i>	
24 FUNERAL DIRECTOR'S SIGNATURE <i>Warner E. Pumphrey, Inc.</i>		25a REC'D BY REGISTRAR <i>Jul 7 '61</i>	
ADDRESS <i>8434 Georgia Avenue Silver Spring, Maryland</i>		25b REGISTRAR'S SIGNATURE <i>Charles E. Frank</i>	



3206

CERTIFICATE OF DEATH

Reg. Dist. No. 02199

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring c. LENGTH OF STAY IN 1b 14 years d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 12,918 Colesville Road		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring d. STREET ADDRESS 12,918 Colesville Road • IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Eugene Dominic Kengla		4. DATE OF DEATH Month Day Year July 31 1961	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 27 1884
9. AGE (In years last birthday) 76 yrs		IF UNDER 1 YEAR Months Days Hours Min 76	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer (Retired)		10b. KIND OF BUSINESS OR INDUSTRY Farm	
11. BIRTHPLACE (State or foreign country) Silver Spring, Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Mr. William F. Kengla		14. MOTHER'S MAIDEN NAME Helen R. Yeabower	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No None None		16. SOCIAL SECURITY NO. None	
17. INFORMANT Mrs. Alice S. Kengla		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 1. DEHYDRATION DUE TO 148X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) 2. CARCINOMA OF ORO-PHARYNGEAL AREA WITH WIDESPREAD METASTASES DUE TO 1 1/2 YEAR (c) CONGESTIVE HEART FAILURE (COMPENSATED) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) CONGESTIVE HEART FAILURE (COMPENSATED)	
19. WAS AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		INTERVAL BETWEEN ONSET AND DEATH 5-6 DAYS	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 7/29 19 61 to 7/31 19 61 , that I last saw the deceased alive on 7/30 19 61 , and that death occurred at 8:20 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED John P. Martin, MD 7/31/61 SANDY SPRING, MD			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 8/3/61	
22c. NAME OF CEMETERY OR CREMATORY St. Johns Cemetery		22d. LOCATION (City, town, or county) (State) Forest Glen Montgomery County Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Warner E. Pumphrey, Inc. 8434 Georgia Avenue		24a. REC'D BY REGISTRAR Aug 2 '61 DATE 24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 may be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 may be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 may be retained by the hospital or attending physician.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>ROCKVILLE</u> c. LENGTH OF STAY IN MO. <u>1 MO.</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>301 POTOMAC STREET</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) e. STATE <u>MARYLAND</u> b. COUNTY <u>MONTGOMERY</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>10 ROCKVILLE</u> d. STREET ADDRESS <u>1301 POTOMAC ST.</u>	
3. NAME OF DECEASED (Type or print) <u>WILLIAM LEACHMAN KEYS</u> First Middle Last 4. DATE OF DEATH <u>JULY 11TH</u> 19 <u>61</u> Month Day Year		5. SEX <u>MALE</u> 6. COLOR OR RACE <u>WHITE</u> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH <u>FEB. 17TH 1895</u> Year Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>CONSTRUCTION</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>RETIRED</u> 11. BIRTHPLACE County & State or foreign country <u>INDEPENDENT HILL VA.</u> 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>THOMAS KEYS</u> 14. MOTHER'S MAIDEN NAME <u>NANCY BEAVERS</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> 16. SOCIAL SECURITY NO. <u>NONE</u> 17. INFORMANT <u>MYRTLE STANG.</u> Address <u>5806 WICOMICO AVE. ROCKVILLE, MD.</u>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>VENTRICULAR FIBRILLATION</u> 4-20-1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>ARTERIO SCLEROSIS</u> DUE TO (c) <u>CORONARY THROMBOSIS</u> ARTERIAL HYPERTENSION	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20. TIME OF INJURY Month, Day, Year <u>19</u> Hour a.m. p.m. 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>12 JUNE, 1961</u> , to <u>12 JULY, 1961</u> , that (I) (we) last saw the deceased alive on <u>8 JULY 1961</u> , and that death occurred at <u>4:55 P.M.</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>Gordon S. Rosenberger</u> 22c. PHYSICIAN'S NAME (Type) <u>GORDON S. ROSENBERGER</u>		22b. DATE SIGNED <u>15 JULY 1961</u> 22d. ADDRESS <u>310 W. MONTGOMERY AVE. ROCKVILLE, MARYLAND</u>	
23a. BURIAL, CREMATION, REMOVAL <u>BURIAL</u> 23b. DATE THEREOF <u>7/14/61</u> 23c. NAME OF CEMETERY OR CREMATORY <u>WOODBINE</u>		23d. LOCATION (City, town or county) <u>MANASSAS, VA.</u> (State)	
24. FUNERAL DIRECTOR'S SIGNATURE <u>W.W. Chambers Co. Washington DC</u> 25a. REC'D BY REGISTRAR <u>JUL 13 '61</u> 25b. REGISTRAR'S SIGNATURE <u>Arthur S. Thomas</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed in the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
8208
82201

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>TAKOMA PARK</u> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>WASH. SAN. & HOSP.</u>		2. USUAL RESIDENCE (Where deceased lived, if inst. put on: Residence before adm. ssion) a. STATE <u>D.C.</u> b. COUNTY c. CITY OR TOWN (if outside of corporate limits, write RURAL and give nearest town) <u>WASHINGTON</u> d. STREET ADDRESS <u>2480-16th St. N.W.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>MERYL GOLDSMITH KRONHEIM</u>		4. DATE OF DEATH <u>7 9 1961</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>4-29-90</u>
9. AGE (In years last birthday) <u>71</u> yrs.		10. IF UNDER 1 YEAR Months Days	11. IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSE WIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <u>ALEXANDRIA, VA.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>GOLDSMITH, EMANUEL</u>		14. MOTHER'S MAIDEN NAME <u>BRAGER, IDA</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT <u>M. KRONHEIM, JR.</u>		Address <u>WASH. D.C.</u>	
18. CAUSE OF DEATH (Enter on only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Convulsion-cerebral</u> DUE TO (b) <u>Complete Art Block - Adams-stokes</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Hypertension, Diabetes Mellitus.</u>		INTERVAL BETWEEN ONSET AND DEATH <u>six wks</u>	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>June 21, 1961</u> , to <u>July 9, 1961</u> , that (I) (we) last saw the deceased alive on <u>7/9/1961</u> , and that death occurred at <u>11:30 A.M.</u> from the causes and on the date stated above			
22a. SIGNATURE <u>Robert A. Hare</u>		22b. DATE SIGNED <u>7/9/61</u>	
22c. PHYSICIAN'S NAME (Type) <u>Robert A. Hare</u>		22d. ADDRESS <u>Takoma Park, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>7-11-61</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>WASHINGTON HEBREW CONG. CEM.</u>		23d. LOCATION (City, town or county) (State) <u>WASHINGTON - D.C.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>B. Dangan Kydonis</u>		25a. REC'D BY REGISTRAR <u>JUL 12 '61</u>	
25b. REGISTRAR'S SIGNATURE <u>Arthur S. Hume</u>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

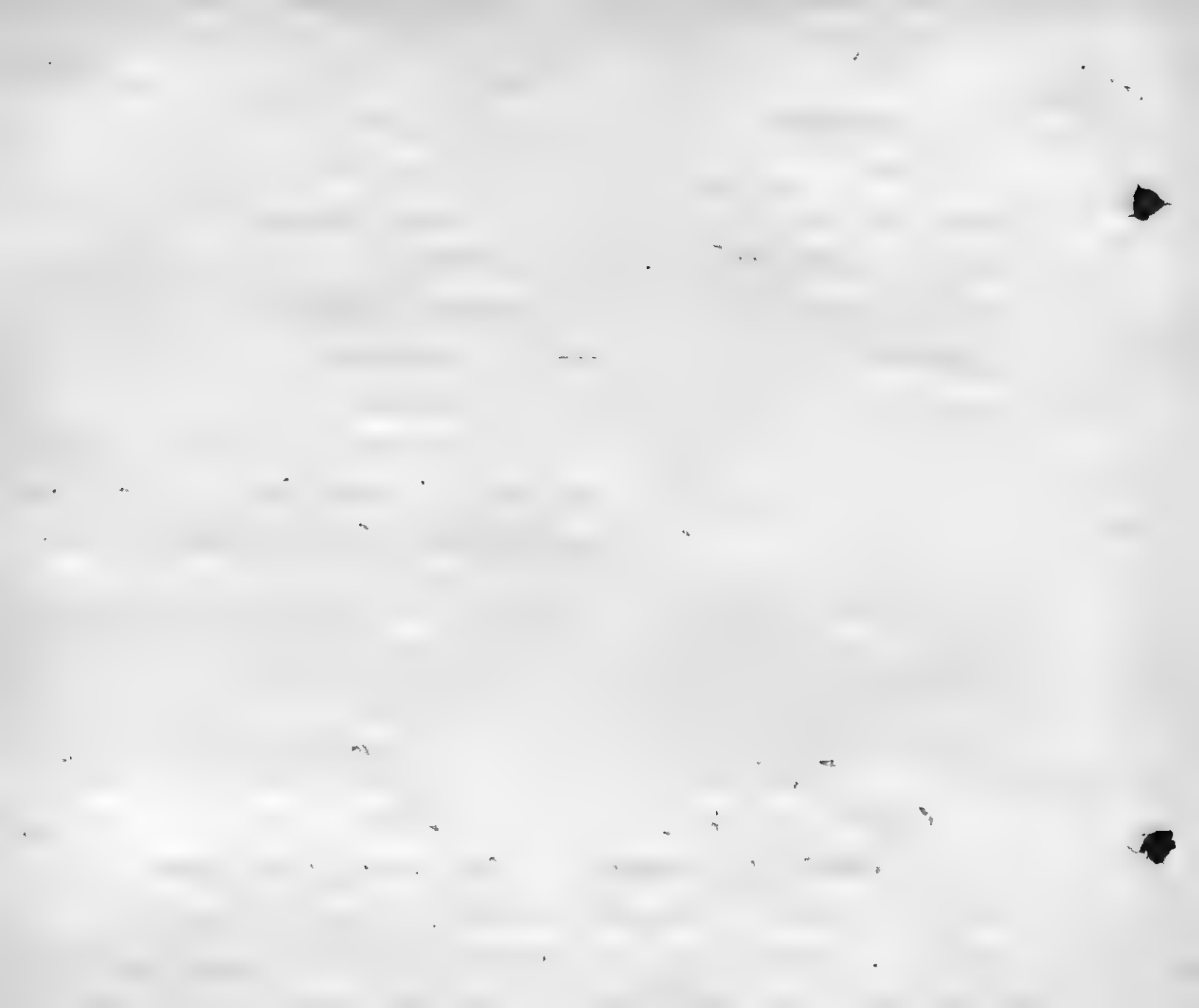
YR A15 (4)
ISM 9/60

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

8209

08202

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Cabin John c. LENGTH OF STAY IN 1b		2. USUAL RESIDENCE (Where deceased lived, if not last one: Residence before admission) a. STATE Maryland b. COUNTY Montgomery c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Cabin John d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) MARGARET B. KUSTER 4. DATE OF DEATH July 31 1961		5. SEX Female 6. COLOR OR RACE White 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH August 31, 1896 9. AGE (In years last birthday) 64 yrs. 10. IF UNDER 1 YEAR 11 Months 0 Days 0 Hours 0 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired) Housewife 10b. KIND OF BUSINESS OR INDUSTRY ----- 11. BIRTHPLACE (County & State or foreign country) Maryland 12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Unknown 14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No 16. SOCIAL SECURITY NO. None 17. INFORMANT (S) Karl Kuster-Morristown, N. Jersey Address -----		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) MYOCARDIAL INFARCTION 42A DUE TO ARTERIOSCLEROTIC CV. DISEASE Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (c) years PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) -----	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/> 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) -----	
20c. TIME OF INJURY Month, Day, Year 19 Hour a.m. ----- p.m. ----- 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) ----- 20f. (City or town) ----- (County) ----- (State) -----		21. I certify that (I) (unhospitalized) attended the deceased from July 19, 1961 to July 31, 1961 , that (I) (was) last saw the deceased alive on July 19, 1961 , and that death occurred at 8 A.M. from the causes and on the date stated above.	
22a. SIGNATURE DeWitt E. DeLawter 22b. DATE SIGNED 7-31-61 22c. PHYSICIAN'S NAME (Type) DeWitt E. DeLawter 22d. ADDRESS 3848 Porter St. NW. Wash D.C.		23a. BURIAL, CREMATION, REMOVAL (Specify) Burial 23b. DATE THEREOF 8/2/61 23c. NAME OF CEMETERY OR CREMATORY Potomac Church Cem. 23d. LOCATION (City, town or county) Potomac, Maryland (State) -----	
24. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey ADDRESS Bethesda, Maryland 25a. REC'D BY REGISTRAR AUG 3 '61 25b. REGISTRAR'S SIGNATURE Arthur S. Kraus			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 may be retained by the hospital or attending physician. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

8210

1. PLACE OF DEATH
a. COUNTY MONTGOMERY MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING
c. LENGTH OF STAY IN 1b 5 months
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) WHEATON Nursing Home

2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)
a. STATE CONN
b. COUNTY NEW HAVEN
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 162 Bishop ST
d. STREET ADDRESS

3. NAME OF DECEASED (Type or print) ALICE Taylor Ladd
First Middle Last

4. DATE OF DEATH 7 21 19 61
Month Day Year

5. SEX FEMALE
6. COLOR OR RACE W
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH 11-26-1884
9. AGE (In years last birthday) 76 yrs. IF UNDER 1 YEAR Months Days Hours Min. IF UNDER 24 HRS.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
10b. KIND OF BUSINESS OR INDUSTRY Umbala India
11. BIRTHPLACE (County & State, or foreign country) U.S.A
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME Edward Taylor
14. MOTHER'S MAIDEN NAME MADELINE Campbell

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) NO
16. SOCIAL SECURITY NO. NONE
17. INFORMANT Penelope L. Wright 4564 Indian Rock Rd. N.W.

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Bronchopneumonia
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Old inactive poliomyelitis

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office building, etc.)
20f. (City or town) May 21, 1961 (County) (State)
21. I certify that (1) (this hospital) attended the deceased from May 21, 1961, to July 21, 1961, that (1) (yes) last saw the deceased alive on July 21, 1961, and that death occurred at 11:15 P.M. from the causes and on the date stated above.

22a. SIGNATURE George C. Buchanan M.D.
22b. DATE SIGNED July 22, 1961
22c. PHYSICIAN'S NAME (Type) George C. Buchanan
22d. ADDRESS 1834 Eye St. N.W., Washington, D.C.

23a. BURIAL, CREMATION, REMOVAL (Specify) CREMATION
23b. DATE THEREOF 7/21/1961
23c. NAME OF CEMETERY OR CREMATORY Cedar Hill
23d. LOCATION (City and county) Prince George Md.
24. FUNERAL DIRECTOR'S SIGNATURE Jos. Hawley Jr. N.W.
25. REC'D BY REGISTRAR 26. REGISTRAR'S SIGNATURE

177

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177

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

8211

08204

1 PLACE OF DEATH a COUNTY Montgomery MARYLAND		2 USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a STATE Maryland b COUNTY Montgomery	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c LENGTH OF STAY IN 1b 181 Days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center		d. STREET ADDRESS 114 Lucas Lane	
3. NAME OF DECEASED (Type or print) First NELL Middle McClure Last (No middle name) LANGDON		4. DATE OF DEATH Month July Day 3 Year 19 61	
5 SEX Female	6. COLOR OR RACE White	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 14 July 1904
9. AGE (In years lost birthday) yrs 56		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk		10b KIND OF BUSINESS OR INDUSTRY Landon School	11. BIRTHPLACE (State or foreign country) Washington, D.C.
13. FATHER'S NAME William McClure		14. MOTHER'S MAIDEN NAME Lulu Harrison	
15. WAS DECEASED EVER IN U S ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16 SOCIAL SECURITY NO. Not available	
17 INFORMANT The Medical Record		Address The Clinical Center, Bethesda 14, Maryland	

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Vasculitis 122.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Rheumatoid Arthritis DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 8 months 10 years
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PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Septicemia with Escherischia Coli		19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
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20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c TIME OF INJURY Hour a. m. _____ p. m. _____	Month. _____ Day. _____ Year 19	20d INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____
20f (City or town) _____ (County) _____ (State) _____			

21 I certify that (I) (this hospital) attended the deceased from **January 3, 1961** to **July 3, 1961**, that (I) (we) last saw the deceased alive on **July 3, 1961** and that death occurred at **6:22 a.m.** from the causes and on the date stated above.

22a SIGNATURE Dr. Daniel V. Kimberg	M.D. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>	22b DATE SIGNED 7/3/61
22c PHYSICIAN'S NAME (Type) DANIEL V. KIMBERG, M.D.		22d ADDRESS The Clinical Center, National Institutes of Health, Bethesda 14, Maryland

23a BURIAL, CREMATION, REMOVAL (Specify) Burial	23b DATE THEREOF 7-6-1961	23c NAME OF CEMETERY OR CREMATORY Arlington Nat'l. Cemetery, Arlington, Va.	23d. LOCATION (City, town, or county) _____ (State) _____
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24 FUNERAL DIRECTOR'S SIGNATURE Joseph J. Kimberg	ADDRESS 1756 Pine Ave, Wash. D.C.	25a REC'D BY REGISTRAR DATE JUL 7 '61	25b REGISTRAR'S SIGNATURE William E. Kimberg
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TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Page 1 of 1. The funeral director, by the hospital or attending physician, after this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

Page 1 of 1

VR A15 (4)
ISM 9/59



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

8212

82205

1 PLACE OF DEATH a. COUNTY <u>Montgomery County</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>MONTGOMERY</u>			
b. CITY OR TOWN (Outside corporate limits, write RURAL and give nearest town) <u>Towson Park</u>				c. CITY OR TOWN (Outside corporate limits, write RURAL and give nearest town) <u>SILVER SPRING</u>			
c. LENGTH OF STAY IN 1b <u>3 days</u>				d. STREET ADDRESS <u>3722 Colesville Road, Apt. 110</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Ida M. Lewis Sanatorium & Hospital</u>				IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3 NAME OF DECEASED (Type or print) First <u>Willie</u> Middle <u>Mae</u> Last <u>Langley</u>				4. DATE OF DEATH Month <u>July</u> Day <u>31</u> Year <u>1961</u>			
5 SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8 DATE OF BIRTH <u>5-21-82</u>	
9 AGE (In years last birthday) <u>79</u> yrs		IF UNDER 1 YEAR Months <u>7</u> Days <u>9</u> Hours <u>0</u> Min <u>0</u>		IF UNDER 24 HRS Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min <u>0</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Homemaker</u>		11 BIRTHPLACE (State or foreign country) <u>MARYLAND</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>William Frankton</u>				14 MOTHER'S MAIDEN NAME <u>Laura Frazier</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) <u>No</u>				16. SOCIAL SECURITY NO <u>577-30-0992A</u>		17. INFORMANT Address <u>Miss Audrey M. Langley</u> <u>1010 - 25th Street, N.W. Washington D.C.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute cerebral hemorrhage, right</u> DUE TO (b) <u>Cardiac decompensation</u> DUE TO (c) <u>Malnutrition</u> INTERVAL BETWEEN ONSET AND DEATH <u>18 hrs</u> <u>Several months</u> <u>Several months</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/></u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part I of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour <u>0</u> a.m. <u>19</u> p.m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21 I certify that (I) (this hospital) attended the deceased from <u>July 28, 1961</u> to <u>July 31, 1961</u> , that (I) (we) last saw the deceased alive on <u>July 31, 1961</u> , and that death occurred at <u>7:30 PM</u> , from the causes and on the date stated above.							
22a. SIGNATURE <u>Bennet A. Porter, Jr.</u> M.D.				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>July 31, 1961</u>	
22c. PHYSICIAN'S NAME (Type) <u>Bennet A. Porter, Jr. M.D.</u>				22d. ADDRESS <u>9301 Colesville Rd., Silver Spring, Md.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>8/3/61</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>Prince George's Maryland</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Warner E. Pumphrey, Inc.</u> ADDRESS <u>8434 Georgia Avenue Silver Spring, Maryland</u>				25a. REC'D BY REG. STRAR <u>AUG 7 '61</u>		25b. REGISTRAR'S SIGNATURE <u>William S. Thomas</u>	

8213

MONTGOMERY STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH

C8206

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution, Residence before admission) a. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Olney				c. LENGTH OF STAY IN 1b Olney			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS Box 53			
3. NAME OF DECEASED (Type or print) First Middle Last Sydney Taylor Lawler				4. DATE OF DEATH Month Day Year July 13 1961			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 2-21-1907	
9. AGE (In years last birthday) 54 yrs		IF UNDER 1 YEAR: Months Days Hours Min.		IF UNDER 24 HRS: Months Days Hours Min.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Teacher - Principal				10b. KIND OF BUSINESS OR INDUSTRY Education		11. BIRTHPLACE (State or foreign country) Virginia, U.S.A.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.				13. FATHER'S NAME Winston Carter Lawler			
14. MOTHER'S MAIDEN NAME Emily Tyler Bronaugh				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no			
16. SOCIAL SECURITY NO. 219-36-8351 212-38-2800				17. INFORMANT Hospital Records.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Acute congestive failure 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) Hypertensive C.V. disease DUE TO (c) Arteriosclerotic heart disease							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
MEDICAL CERTIFICATION 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) Olney Montgomery Md.							
21. I certify that (I) (this hospital) attended the deceased from Dec 19 56 to July 13 1961 , that (I) (we) last saw the deceased alive on July 13 1961 , and that death occurred at 12:30 PM , from the causes and on the date stated above							
22a. SIGNATURE Lillian K. Ziegler M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22c. PHYSICIAN'S NAME (Type) Lillian K. Ziegler							
22d. ADDRESS Olney, Md.							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial							
23b. DATE THEREOF							
23c. NAME OF CEMETERY OR CREMATORY Parklawn							
23d. LOCATION (City, town, or county) (State) Montgomery Co. Md.							
24. FUNERAL DIRECTOR'S SIGNATURE Francis H. Barber ADDRESS Laytonsville, Md.							
25a. REC'D BY REGISTRAR JUL 17 '61							
25b. REGISTRAR'S SIGNATURE Arthur L. K...							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled out, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any other person is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. **FUNERAL DIRECTOR** Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 9/60

2214 MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08207

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Montg</u>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Rockville</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Rockville</u>	
c. LENGTH OF STAY in lb <u>15 yrs</u>		d. STREET ADDRESS <u>1104 Charles St</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)			
3. NAME OF <u>Richard Kenneth Lazarus</u> (Type or print) First Middle Last		4. DATE OF DEATH <u>July 3 1961</u> Month Day Year	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>9-24-'43</u> Month Day Year
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>waiter</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>restaurant</u>	
11. BIRTHPLACE (State or foreign country) <u>DC</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.C.</u>	
13. FATHER'S NAME <u>Myler Lazarus</u>		14. MOTHER'S MAIDEN NAME <u>Helen Mosley</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>213-40-8533</u>	
17. INFORMANT <u>Myler Lazarus (father)</u>		18. ADDRESS <u>Stuen 2</u>	
18. CAUSE OF DEATH (Enter on only one cause per line for (a), (b), and (c).)			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral hemorrhage & laceration</u> 976X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>bullet wound thru skull</u> DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a). 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Self-inflicted bullet wound thru skull</u>	
20c. TIME OF INJURY Month, Day, Year <u>7-3 1961</u> Hour a.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>		20f. (City or town) <u>Rockville</u> (County) <u>Montg</u> (State) <u>md</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from. Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Frank J. Broschatt</u>		M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>FRANK J. BROSCHEAT</u>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>7/6/61</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill</u>		22d. LOCATION (City, town, or country) <u>Suitland, Maryland</u> (State)	
23. FUNERAL DIRECTOR <u>Tyson Wheeler Funeral Home-1331 E. Montg. Ave. Rockville, Maryland</u>		24a. REC'D BY REGISTRAR <u>JUL 6 '61</u> 24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
8215											
CERTIFICATE OF DEATH											
08203											
1. PLACE OF DEATH a. COUNTY Montgomery				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Montgomery							
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Kensington				c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Kensington							
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Carroll Hall				d. STREET ADDRESS 9633 Old Spring Road							
3. NAME OF DECEASED (Type or print) FRED James				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
5. SEX Male				6. COLOR OR RACE White				7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Postmaster				10b. KIND OF BUSINESS OR INDUSTRY U. S. Govt.				8. DATE OF BIRTH Sept. 28, 1873			
13. FATHER'S NAME Julius Leonard				11. BIRTHPLACE (County & State, or foreign country) Michigan				9. AGE (in years last birthday) 87 yrs. 10 months 0 days			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No				16. SOCIAL SECURITY NO. None				12. CITIZEN OF WHAT COUNTRY? USA			
17. INFORMANT James D. Leonard-Son-11809 Grandview Ave.				14. MOTHER'S MAIDEN NAME Sarah E. Everett				Address Silver Spring, Md.			
18. CAUSE OF DEATH (Enter on y one cause per line for (a), (b), and (c).) a. DEATH WAS CAUSED BY: 260X IMMEDIATE CAUSE (a) GANGRENE - RIGHT TOES AND FOOT b. CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last. DIABETES MELLITUS c. GENERALIZED ARTERIOSCLEROSIS				PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) SENILITY							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				INTERVAL BETWEEN ONSET AND DEATH 60 DAYS							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Hour a.m. 19 p.m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town)				20g. (County)				20h. (State)			
21. I certify that (I) (this hospital) attended the deceased from MARCH 24, 1954 to JULY 28, 1961 , that (I) (we) last saw the deceased alive on JULY 28, 1961 , and that death occurred at 3:30 AM , from the causes and on the date stated above.											
22a. SIGNATURE Henry M. Lowden				22b. DATE SIGNED 7/28/61				22c. PHYSICIAN'S NAME (Type) Henry M. Lowden, M.D.			
22d. ADDRESS 3206 Maryland Dr. Chevy Chase, Md.				22e. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>				22f. ADDRESS			
23a. BURIAL, CREMATION, REMOVAL (Specify) 7/31/1961 Burial				23b. DATE THEREOF				23c. NAME OF CEMETERY OR CREMATORY Rock Creek Cemetery			
23d. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey				23e. ADDRESS Bethesda, Maryland				23f. LOCATION (City, town or county) Washington D.C.			
24a. REC'D BY REGISTRAR JUL 31 '61				24b. REGISTRAR'S SIGNATURE Arthur S. Thane				24c. REGISTRAR'S SIGNATURE			

8216

CERTIFICATE OF DEATH

Reg. Dist. No.

C8209

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Olney</u>				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Montgomery General</u>				d. STREET ADDRESS <u>110 Russell Avenue</u>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>WILLIAM T. LEWIS</u>				4. DATE OF DEATH Month Day Year <u>July 26 1961</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>April 1, 1883</u>		9. AGE (In years last birthday) <u>78</u> yrs	10. IF UNDER 1 YEAR: IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Pullman Conductor</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Rail Road</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>US</u>				13. FATHER'S NAME <u>Joseph H. Lewis</u>			
14. MOTHER'S MAIDEN NAME <u>Rachel Matthews</u>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>			
16. SOCIAL SECURITY NO. <u>709-09-0902</u>				17. INFORMANT <u>Bertram R. Burroughs</u> Address <u>439 N. Frederick Avenue Gaithersburg, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Pulmonary Emboli</u> DUE TO <u>origin Prostatic Veins</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Prostatic Carcinoma</u> DUE TO (c) _____							INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u> <u>2 years</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>1. Coronary Thrombosis 2. Uremia</u>							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>May 1961</u> to <u>July 26, 1961</u> , that I last saw the deceased alive on <u>July 26, 1961</u> , and that death occurred at <u>10:15 A.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <u>105 Russell Ave. 7-26 Gaithersburg, Md. -61</u>							
ACTUAL SIGNATURE <u>Jack Schumacher</u> M.D.							
PHYSICIAN'S NAME (Type) <u>Jack Schumacher</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>7/28/61</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Forest Oak</u>		22d. LOCATION (City, town, or county) (State) <u>Gaithersburg, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Tyson Wheeler Funeral Home</u>				ADDRESS <u>1331 E. Montg. Ave. Rockville, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>JUL 28 '61</u>	
				24b. REGISTRAR'S SIGNATURE <u>Arthur L. Hume</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filled out by the funeral director, and page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MEDICAL CERTIFICATION

1. PLACE OF DEATH
a. COUNTY Montgomery
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Silver Spring c. LENGTH OF STAY IN 1b 6 mo
d. NAME OF HOSPITAL OR INSTITUTION (if not a hospital, give street address) 9826 Cherry Tree Ln
3. NAME OF DECEASED (Type or print) Mollie Tillie Liebman
5. SEX Female 6. COLOR OR RACE White 7. MARRIED ☐ NEVER MARRIED ☐ 8. DATE OF BIRTH Oct 9 1897
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife 10b. KIND OF BUSINESS OR INDUSTRY Own Home
13. FATHER'S NAME Harry Weinberg 14. MOTHER'S M maiden name Fannie Unknown

2. USUAL RESIDENCE (Where deceased lived, if institution - Residence before admission)
a. STATE md b. COUNTY Monty
c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Silver Spring
d. STREET ADDRESS 19826 Cherry Tree Ln
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒
9. AGE (in years last birthday) 63 yrs. 10. UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.
11. BIRTHPLACE (State or foreign country) Pa 12. CITIZEN OF WHAT COUNTRY? U.S.A.
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No 16. SOCIAL SECURITY NO. --- 17. INFORMANT Mrs. Norman H. Roth, 9826 Cherry Tree Lane, Silver Spring, Md.

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Asphyxiation
DUE TO Carbon dioxide poisoning
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) 174
DUE TO (c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I. (a)
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒
20a. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING CAUSE OF DEATH. Found dead with plastic bag over head, twisted about neck
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year 7-1-1961 20d. INJURY OCCURRED While at work ☐ Not While at work ☒
20e. PLACE OF INJURY (home, farm, factory, street, office bldg., etc.) Home 20f. (City or town) Silver Spring (County) Monty (State) md
21 I certify that I took charge of the remains described above, held an Autopsy ☐ Inspection ☒ Inquiry ☒ and in my opinion death resulted from. Natural causes ☐ Accident ☐ Suicide ☒ Homicide ☐ Undetermined manner ☐
CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☐ DEPUTY MEDICAL EXAMINER ☒
DATE SIGNED 7-1-61
22a. BURIAL, CREMATION, REMOVAL (Specify) CREMATION 22b. DATE THEREOF JULY 2, 1961 22c. NAME OF CEMETERY OR CREMATORY FORT LINCOLN CREMATORY 22d. LOCATION (City, town, or country) (State) PRINCE GEORGE'S COUNTY, MD.
23. FUNERAL DIRECTOR ADDRESS WALTER E. PUMPHREY, INC., SILVER SPRING, DM.
Raymond A. Ziska
24a. REC'D BY REGISTRAR JUL 5 '61 24b. REGISTRAR'S SIGNATURE Wm. S. Kraus



TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

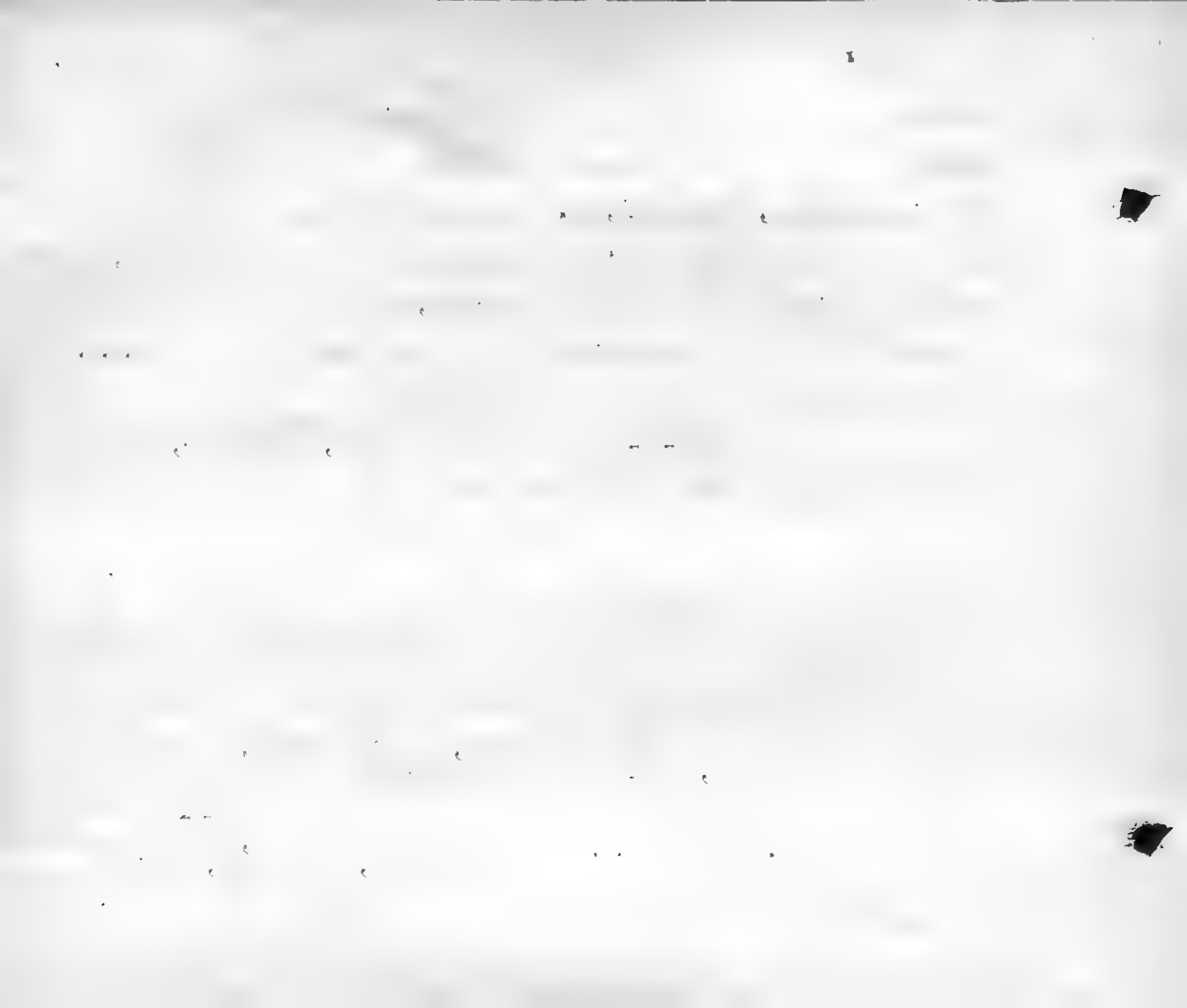
CERTIFICATE OF DEATH

2218

08211

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda c. LENGTH OF STAY IN 1b 51 days d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Pennsylvania b. COUNTY Chester c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 75 x d. STREET ADDRESS 103 East 8th Street e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) First Middle Last Dorothea Shirley Lindley		4. DATE OF DEATH Month Day Year July 7, 19 61				
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH March 20, 1910	9. AGE (In years lost birthday) yrs 51	IF UNDER 1 YEAR Months Days Hours Min. 9th mo	IF UNDER 24 HRS Hours Min. 25 hrs
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Bookkeeper		10b. KIND OF BUSINESS OR INDUSTRY Bookkeeping		11. BIRTHPLACE (State or foreign country) North Dakota		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Joseph Donaldson			14. MOTHER'S MAIDEN NAME Helen Kelly			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) [If yes, give war or dates of service] No		16. SOCIAL SECURITY NO. 202-18-6690		17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Irreversible shock 171X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) Carcinoma of the cervix with DUE TO radical pelvic exenteration (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Marked obesity INTERVAL BETWEEN ONSET AND DEATH 18 hrs 9th mo 25 hrs						
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from May 17, 1961 to July 7, 1961 that (I) (we) last saw the deceased alive on July 7, 1961 and that death occurred on July 7, 1961 at 3:00PM from the causes and on the date stated above						
22a. SIGNATURE Robert H. Wilkins, M.D.		ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> 7-8-61		27b. DATE SIGNED		
22c. PHYSICIAN'S NAME (Type) Robert H. Wilkins M.D.		22d. The Clinical Center, National Institutes of Health, Bethesda 14, Maryland				
23a. BURIAL, CREMATION, REMOVAL (Specify) Funeral		23b. DATE THEREOF July 10-61		23c. NAME OF CEMETERY OR CREMATORY Fort Lincoln		23d. LOCATION (City, town, or county) (State) Blacksburg Md
24. FUNERAL DIRECTOR'S SIGNATURE Summers Bros		ADDRESS 1661-gd Hope Rd S E		25a. REC'D BY REGISTRAR UL 19 61		25b. REGISTRAR'S SIGNATURE Charles S. K...

Wash DC



CERTIFICATE OF DEATH

Reg. Dist. No. 08212

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>11</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chevy Chase</u>		c. LENGTH OF STAY IN 1b <u>52</u> <u>Chevy Chase</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>2900 Daniel Road</u>		d. STREET ADDRESS <u>2900 Daniel Road</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Bernard F. Locraft, Jr</u>		4. DATE OF DEATH Month <u>July</u> Day <u>3rd</u> Year <u>1961</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept 8th 1902</u>
9. AGE (In years last birthday) <u>58</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Civil Engineer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Washington, D. C.</u>	
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Bernard F. Locraft, Sr</u>		14. MOTHER'S MAIDEN NAME <u>Marie. De Lucy</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <u>Vonnette Locraft, 2900 Daniel Road</u>	
17. INFORMANT <u>Vonnette Locraft, 2900 Daniel Road</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Generalized metastatic carcinoma</u> <u>1539</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Carcinoma, large bowel</u> DUE TO (c) <u> </u>		INTERVAL BETWEEN ONSET AND DEATH <u>7 months</u> <u>12 months</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u> </u> p. m. <u> </u> 19 <u> </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Sept 30</u> , 19 <u>60</u> , to <u>July 3</u> , 19 <u>61</u> , that I last saw the deceased alive on <u>July 3</u> , 19 <u>61</u> , and that death occurred at <u>8</u> A. M. from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Frank R. Shea</u>		ADDRESS (Street, city or town, state) <u>4100 - 22nd St, N.E.</u>	
PHYSICIAN'S NAME (Type) <u>FRANK R. SHEA</u>		DATE SIGNED <u>Washington, D.C.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE <u>July 5/61</u>	22c. NAME OF CEMETERY OR CREMATORY <u>St. Clare Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Washington, D.C.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. F. Costello</u>		24a. REC'D BY REGISTRAR DATE <u>JUL 5 '61</u>	
ADDRESS <u>1722 N. Cap & Ward St</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur J. Thomas</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

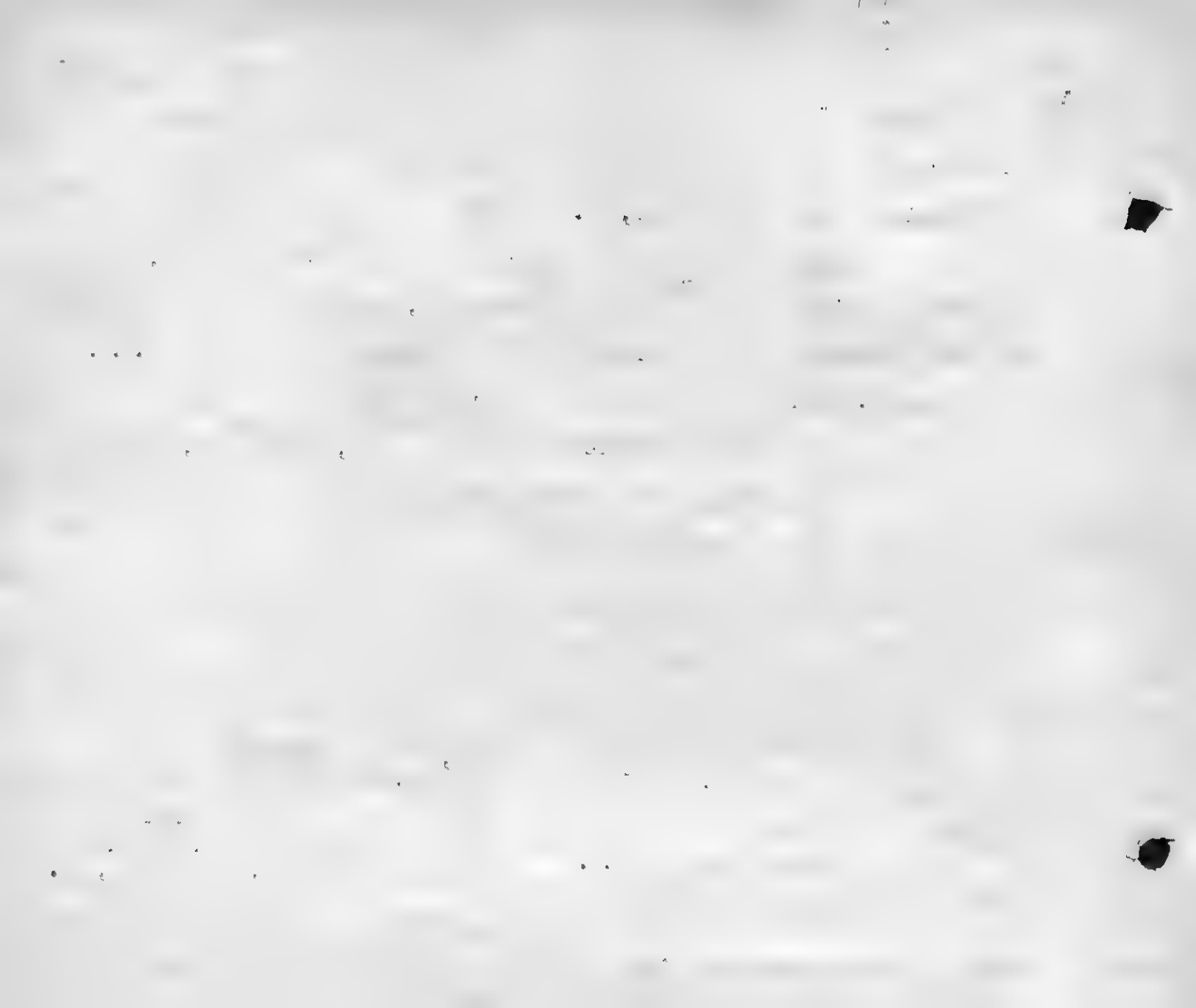
CERTIFICATE OF DEATH

3220

08213

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND b. CITY OR TOWN (If outside of corporate limits, write RURAL and give nearest town) Bethesda c. LENGTH OF STAY IN 1b 1 Day d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) The Clinical Center, Bethesda 14, Md.		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Virginia b. COUNTY Scott c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Gate City d. STREET ADDRESS Route #1 e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Edgar Ormsby Logan First Middle Last		4. DATE OF DEATH July 11, 1961 Month Day Year	
5. SEX Male White 6. COLOR OR RACE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH February 14, 1906 Months Days Hours Min.		9. AGE (in years last birthday) 55 yrs. IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS.: Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Insurance Adjustor 10b. KIND OF BUSINESS OR INDUSTRY Insurance 11. BIRTHPLACE (Country & State, or foreign country) Indiana 12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Ormsby H. Logan		14. MOTHER'S MAIDEN NAME Augusta Loper	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? NO (Yes, no, or unknown) (If yes, give year or dates of service)		16. SOCIAL SECURITY NO Unascertainable 17. INFORMANT The Medical Records The Clinical Center, Bethesda 14, Maryland	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congestive Heart Failure 4:30 P.M. DUE TO Myocardial Infarction Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 4 Hours	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from July 10, 1961, to July 11, 1961 that (I) (we) last saw the deceased alive on July 11, 1961, and that death occurred at 3:40 P.M. from the causes and on the date stated above.			
22a. SIGNATURE Thomas E. Gaffney		22b. DATE SIGNED 7-11-61	
22b. PHYSICIAN'S NAME (Type) Thomas E. Gaffney M.D.		22d. ADDRESS The Clinical Center, National Institutes of Health, Bethesda 14, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 7/12/61	
23c. NAME OF CEMETERY OR CREMATORY Maple Grove Cemetery		23d. LOCATION (City, town or county) Brookville, Indiana	
24. FUNERAL DIRECTOR'S SIGNATURE Paul H. Hume		25a. REC'D REGISTRAR 4812 GA. AVE N.W.	
25b. REGISTRAR'S SIGNATURE Carlton S. Hume		DATE JUL 13 '61	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death.



TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

8221

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

08216

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>M</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Shiloh</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Tekoma Park</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>#4 Oldham Road</u>		d. STREET ADDRESS <u>7166 Highland Ave.</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>LEE</u> Middle <u>LYNN</u> Last <u>MARCHANT</u>		4. DATE OF DEATH Month <u>July</u> Day <u>9</u> Year <u>1961</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 6 - 1893</u>
9. AGE (In years last birthday) <u>68</u> yrs		10. UNDER 1 YEAR IF UNDER 24 HRS Months <u></u> Days <u></u> Hours <u></u> Min <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Owner of Trucking Co</u>		10b. KIND OF BUSINESS OR INDUSTRY <u></u>	
11. BIRTHPLACE (State or foreign country) <u>South Texas, U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>George Marchant</u>		14. MOTHER'S MAIDEN NAME <u>Laura Belle Miller</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u>no</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO <u>57709-9252</u>	
17. INFORMANT <u>Mrs. Charlotte Marchant</u>		Address <u>7166 Highland Ave. Tekoma Park</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>acute myocardial infarction</u> DUE TO (b) <u>coronary atherosclerosis</u> DUE TO (c) <u>5 yrs.</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH <u>3 min.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m. <u></u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (1) (this hospital) attended the deceased from <u>May 1960</u> to <u>June 1961</u> , that (2) (we) last saw the deceased alive on <u>June 1 1961</u> , and that death occurred at <u>10 P.M.</u> from the causes and on the date stated above			
22a. SIGNATURE <u>James R. Coleman MD</u>		22b. DATE SIGNED <u>July 9, 1961</u>	
22c. PHYSICIAN'S NAME (Type) <u>JAMES R. COLEMAN</u>		22d. ADDRESS <u>733 Sigo Avenue, Silver Spring, Md.</u>	
23a. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>July 12-1961</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>St. Luke's Mausoleum</u>		23d. LOCATION (City, town, or county) (State) <u>Prince Georges County Md</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>J. Arthur Hall</u>		25a. REC'D BY REGISTRAR <u>Jul 11 '61</u>	
ADDRESS <u>251 Carroll St NW</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Himes</u>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 may be retained by the hospital or attending physician. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

2222		08217	
1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u> c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Riverdale</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Suburban</u>		d. STREET ADDRESS <u>6709-3rd, St.</u>	
3. NAME OF DECEASED (Type or print) <u>JOHN DEAN Mc Ahee</u>		4. DATE OF DEATH Month <u>July</u> Day <u>13</u> Year <u>1961</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10/19/25</u>
9. AGE (In years, if UNDER 1 YEAR, if UNDER 24 HRS., last birthday) <u>35</u> yrs. Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>foreman</u>	
10b. KIND OF BUSINESS OR INDUSTRY <u>General Contractor</u>		11. BIRTHPLACE (County & State or foreign country) <u>South Carolina</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>Deane Mc Ahee</u>	
14. MOTHER'S MAIDEN NAME <u>Corn Lee</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>Yes</u> <u>World War II</u>	
16. SOCIAL SECURITY NO. <u>250-20-9263</u> (Brother in law)		17. INFORMANT <u>AN Wynn</u> Address <u>3560 Glenmont Ave SE Wash. DC.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>VENTRICULAR FIBRILLATION</u> DUE TO <u>ATHEROSCLEROSIS</u> DUE TO <u>CORONARY THROMBOSIS</u> CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>5 YEARS</u> <u>6 MONTHS</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I: (a) <u>RHEUMATIC HEART DISEASE</u>		INTERVAL BETWEEN ONSET AND DEATH <u>30 MINUTES</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Hour <u>19</u> a.m. <u>19</u> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (1) (this hospital) attended the deceased from <u>13 JULY 1961</u> to <u>14 JULY 1961</u> , that (1) (we) last saw the deceased alive on <u>13 JULY 1961</u> , and that death occurred at <u>11:30 PM</u> , from the causes and on the date stated above.			
22a. SIGNATURE <u>Gordon S. Rosenberger</u> M.D.		22b. DATE SIGNED <u>13 JULY 1961</u>	
22c. PHYSICIAN'S NAME (Type) <u>GORDON S. ROSENBERGER</u>		22d. ADDRESS <u>310 W. MONTGOMERY AVE ROCKVILLE, MARYLAND</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF <u>Burial July 18, 1961</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Fort Lincoln</u>	23d. LOCATION (City, town or county) (State) <u>Bladensburg Md.</u>
24. FUNERAL DIRECTOR'S SIGNATURE <u>W. W. Chambers Co.</u>		25. REC'D BY REGISTRAR <u>DAVID L. 8/61</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles S. Hume</u>			

1
FOR STATE
HEALTH DEPT.

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
8223 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 82215

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Monty</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Suburban Hosp</u>		d. STREET ADDRESS <u>15715 Greenlawn Dr</u>	
3. NAME OF DECEASED (Type or print) <u>Dorothy Harriet McCracken</u>		4. DATE OF DEATH <u>July 22 1961</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 23, - 1919</u>
9. AGE (In years last birthday) <u>41</u> rs. <u>11</u> Months <u>29</u> Days		10. UNDER 1 YEAR IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Sec. Army map service</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>DC</u>	
11. BIRTHPLACE (State or foreign country) <u>U.S.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.C.</u>	
13. FATHER'S NAME <u>John C. Weissman</u>		14. MOTHER'S MAIDEN NAME <u>Burton Miller</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>579-10-6747</u>	
17. INFORMANT <u>Jan E. McCracken - Sister</u>		Address	
18. CAUSE OF DEATH (Enter on one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> 1201 DUE TO Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause last. DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from. Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Frank J. Broschatt</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>FRANK J. Broschatt</u>		M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>7/26/1961</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Parklawn Cemetery</u>		22d. LOCATION (City, town, or country) (State) <u>Rockville Maryland</u>	
23. FUNERAL DIRECTOR <u>Robert A. Pumphrey</u>		24a. REC'D BY REGISTRAR <u>JUL 25 '61</u>	
ADDRESS <u>Bethesda, Maryland</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any change is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

Dr. Brochart notified and approved

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND									
<div style="display: flex; justify-content: space-between;"> 8224 CERTIFICATE OF DEATH 08219 </div>									
1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda c. LENGTH OF STAY IN 1b D.O.A.					2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE Maryland b. COUNTY Montgomery c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda d. STREET ADDRESS 6705 Brigadoon Dr.				
3. NAME OF DECEASED (Type or print) First Joseph Middle Milicke Last 					4. DATE OF DEATH Month July Day 2 Year 1961				
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 2/2/1890		9. AGE (In years last birthday) 70 1/2 yrs	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY Private Industry		11. BIRTHPLACE (State or foreign country) Europe		12. CITIZEN OF WHAT COUNTRY? U.S.A 25 yrs.			
13. FATHER'S NAME Unknown					14. MOTHER'S MAIDEN NAME Unknown				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 291-03-9960		17. INFORMANT Daughter Mrs. Sophia Moreland Address Same as above					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Complete Heart Block DUE TO Myocardial Infarction Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerosis of Heart DUE TO Coronary Disease (c) 								INTERVAL BETWEEN ONSET AND DEATH 3 1/2 hrs 2 yrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) none									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that death occurred at _____ M., from the causes and on the date stated above.									
22a. SIGNATURE William H. Killay M.D.					22b. ADDRESS 10222 Falls Road, Potomac, Md.				
22c. PHYSICIAN'S NAME (Type) William H. Killay					22d. ADDRESS 10222 Falls Road, Potomac, Md.				
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 7/6/61		23c. NAME OF CEMETERY OR CREMATORY Parklawn Cemetery		23d. LOCATION (City, town, or county) (State) Rockville, Maryland			
24. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey ADDRESS Bethesda, Maryland					25a. REC'D BY REGISTRAR JUL 6 '61		25b. REGISTRAR'S SIGNATURE William S. Pumphrey		

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

8225

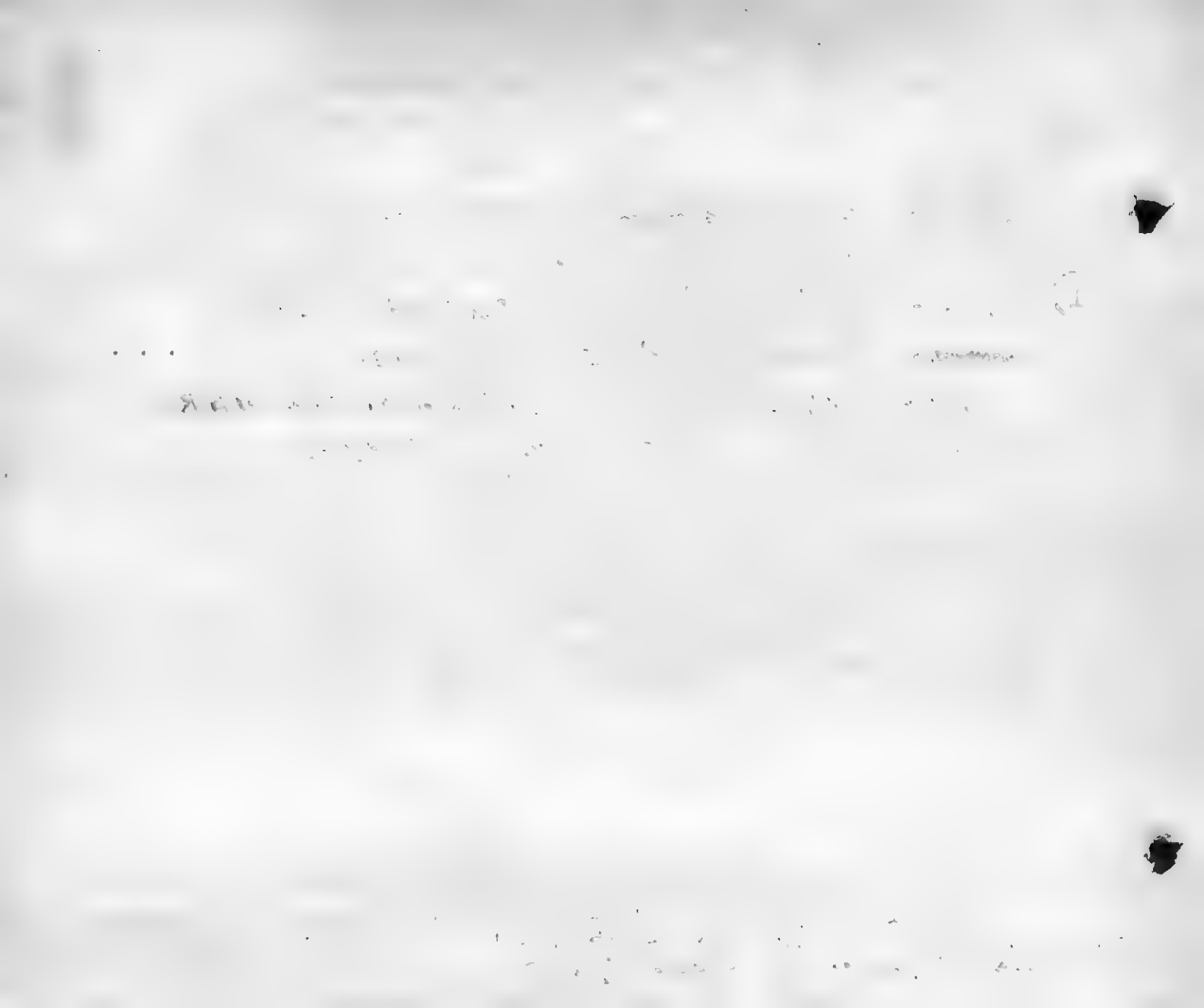
08220

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

(M)

(I)

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Jakoma Park</u> c. LENGTH OF STAY IN IS <u>1 day</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Washington San. & Hosp</u>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Hyattsville</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>1909 Erie St.</u> d. STREET ADDRESS <u>1909 Erie St.</u> e. RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>															
3. NAME OF DECEASED (Type or print) <u>Charles Henry Miller</u>		4. DATE OF DEATH Month <u>7</u> Day <u>2</u> Year <u>1961</u>		5. SEX <u>MALE</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>6/25/93</u>		9. AGE (in years last birthday) <u>68</u> yrs.		10. IF UNDER 1 YEAR Months <u>6</u> Days <u>8</u>		11. IF UNDER 24 HRS. Hours <u>36</u> Min. <u>00</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Engineer (Retired)</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Printing Office</u>				10c. BIRTHPLACE (Country, State, or foreign country) <u>Colorado</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>JAMES MILLER</u>				14. MOTHER'S MAIDEN NAME <u>MARIANNE GRANDIER</u>				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>WWI</u>				16. SOCIAL SECURITY NO. <u>—</u>				17. INFORMANT <u>Hosp record.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumonia Terminal</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>IX</u> DUE TO (c) <u>Cerebral Vascular Hemorrhage</u>																INTERVAL BETWEEN ONSET AND DEATH <u>6-8 hrs.</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)																19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)																			
20c. TIME OF INJURY Hour <u>19</u> a.m. <u>19</u> p.m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)							
21. I certify that (I) (this hospital) attended the deceased from <u>Jan 1950</u> , to <u>July 2, 1961</u> , that (I) (we) last saw the deceased alive on <u>July 2, 1961</u> , and that death occurred at <u>2:25</u> PM, from the causes and on the date stated above.																			
22a. SIGNATURE <u>Robert B. Irey</u>																22b. DATE SIGNED			
22c. PHYSICIAN'S NAME (Type) <u>ROBERT B. IREY</u>				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>				22d. ADDRESS <u>7105 Riggs Rd Hyattsville, Md.</u>											
23a. BURIAL, CREMATION REMOVAL (Specify) <u>removal</u>				23b. DATE THEREOF <u>7/5/61</u>				23c. NAME OF CEMETERY OR CREMATORY <u>Cave Hill Cemetery</u>				23d. LOCATION (City, town or county) (State) <u>Louisville, Kentucky</u>							
24. FUNERAL DIRECTOR'S SIGNATURE <u>Mr. S. A. Nuccio</u>																25. REC'D BY REGISTRAR <u>JUL 5 61</u>		25b. REGISTRAR'S SIGNATURE <u>William A. Nuccio</u>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed 24 hours after death. Pages 1 and 2 should be retained by the hospital or attending physician. Pages 3 and 4 should be retained by the funeral director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

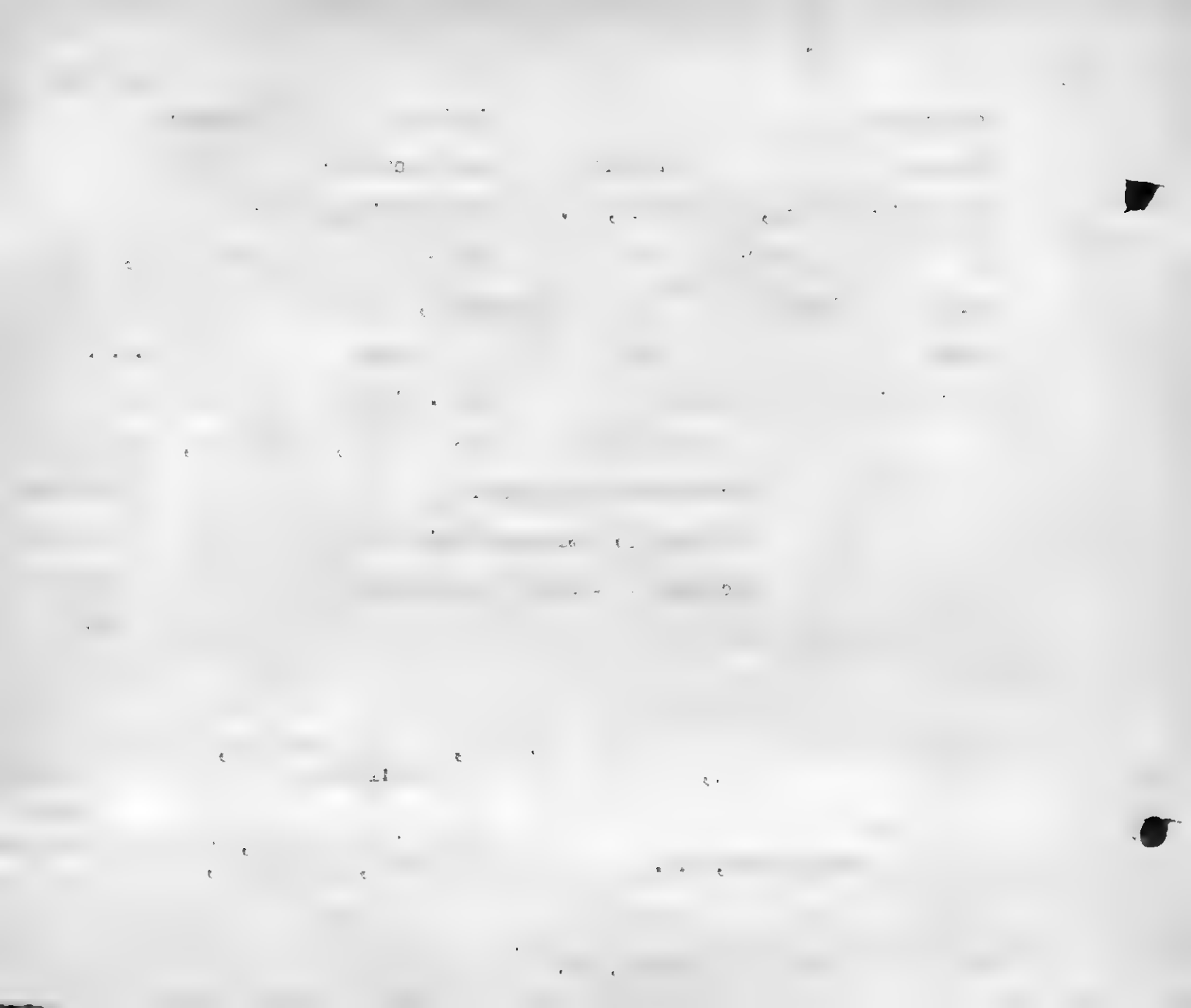
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

8226

82261

1. PLACE OF DEATH a. COUNTY Montgomery		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) STATE Virginia b. COUNTY Albemarle	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Charlottesville	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) The Clinical Center, Bethesda 14, Md.		d. STREET ADDRESS 1612 Cambridge Circle	
3. NAME OF DECEASED (Type or print) Sheffey Guy Miller		4. DATE OF DEATH July 27, 1961	
5. SEX Male		6. COLOR OR RACE White	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH February 2, 1900	
9. AGE (in years last birthday) 61 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY Farm	
11. BIRTHPLACE (County & State, or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME William Miller		14. MOTHER'S MAIDEN NAME Ida M. Williams	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) No		16. SOCIAL SECURITY NO. Unavailable	
17. INFORMANT The Medical Records		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Ventricular fibrillation DUE TO Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. (b) Secondary to Mitral Myocardial Infarct DUE TO (c) Secondary to Coronary Atherosclerosis	
PART I. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) Myotonic Dystrophy		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part I of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from July 5, 1961 to July 27, 1961 , that (I) (we) last saw the deceased alive on July 27, 1961 , and that death occurred at 9:10 PM the causes and on the date stated above.			
22a. SIGNATURE Thomas Vates		22b. DATE 7/28/61	
22c. PHYSICIAN'S NAME (Type) THOMAS VATES, M.D.		22d. ADDRESS The Clinical Center, National Institutes of Health, Bethesda 14, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 7-29-61	
23c. NAME OF CEMETERY OR CREMATORY Evergreen		23d. LOCATION (City, town or county) (State) Roanoke, Virginia	
24. FUNERAL DIRECTOR'S SIGNATURE By: C.M. Gauer		25a. REC'D BY REGISTRAR JUL 31 '61	
25b. REGISTRAR'S SIGNATURE Arthur S. Frank			



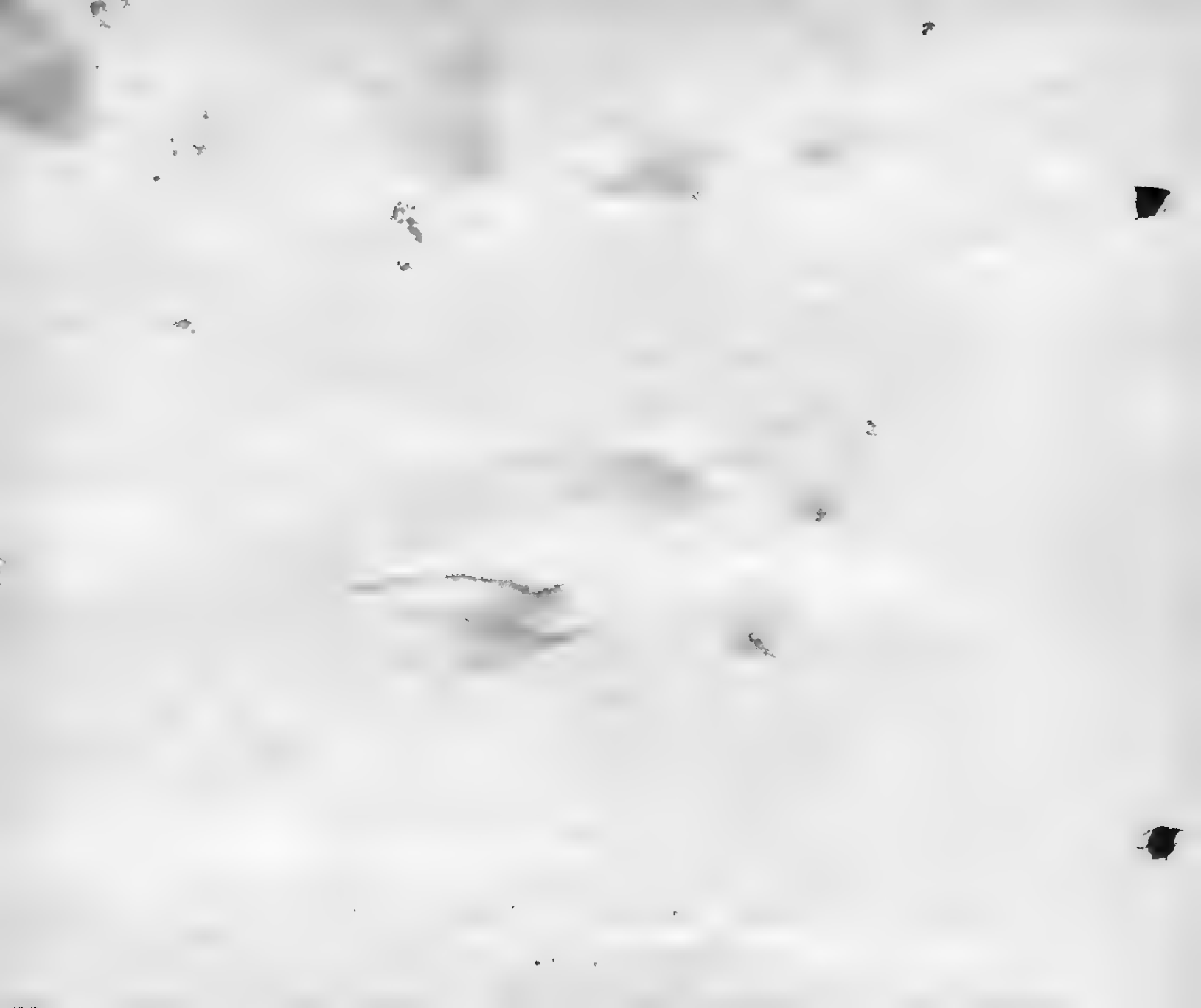
TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any other action is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

M

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

8222 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 03222

<p>1. PLACE OF DEATH COUNTY <u>Montgomery</u> MARYLAND</p> <p>b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>LaKoma Park</u></p> <p>c. LENGTH OF STAY IN <u>1 Hour</u></p> <p>d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Washington Sanitarium & Hosp.</u></p>				<p>2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)</p> <p>a. STATE <u>Maryland</u> b. COUNTY <u>Howard</u></p> <p>c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Woodbine</u></p> <p>d. STREET ADDRESS <u>134-2</u></p>			
<p>3. NAME OF DECEASED (Type or print) <u>James Irving Mitchell</u></p>				<p>4. DATE OF DEATH Month <u>7</u> Day <u>26</u> Year <u>1961</u></p>			
<p>5. SEX <u>M</u></p>		<p>6. COLOR OR RACE <u>W</u></p>		<p>7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/></p>		<p>8. DATE OF BIRTH <u>9-22-05</u></p>	
<p>10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farm worker laborer Construction</u></p>				<p>11. BIRTHPLACE (State or foreign country) <u>Maryland</u></p>			
<p>12. CITIZEN OF WHAT COUNTRY? <u>U-S A</u></p>				<p>13. FATHER'S NAME <u>Alexander Mitchell</u></p>			
<p>14. MOTHER'S MAIDEN NAME <u>Unknown?</u></p>				<p>15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>yes</u> <u>WW II</u></p>			
<p>16. SOCIAL SECURITY NO. <u>219-23-7565</u></p>				<p>17. INFORMANT <u>Self.</u></p>			
<p>18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)</p> <p>PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>HEMORRHAGE, PULMONARY, MASSIVE</u></p> <p>(b) <u>TUBERCULOSIS, PULMONARY, EXTENSIVE</u></p> <p>(c) <u>BILATERAL</u></p> <p>Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. <u>SUDDEN</u></p> <p>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a), (b), and (c). <u>MONTHS.</u></p>							
<p>19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/></p>							
<p>20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.</p> <p>20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)</p>							
<p>20c. TIME OF INJURY Hour <u>19</u> e.m. p.m.</p>		<p>20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/></p>		<p>20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)</p>		<p>20f. (City or town) (County) (State)</p>	
<p>21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/></p>							
<p>ACTUAL SIGNATURE <u>Frank J. Broschert</u></p>				<p>CHIEF MEDICAL EXAMINER <input type="checkbox"/></p>			
<p>EXAMINER'S NAME (Type) <u>FRANK J. Broschert</u></p>				<p>ASSISTANT MEDICAL EXAMINER <input type="checkbox"/></p>			
<p>22a. BURIAL CREMATION REMOVAL (Specify) <u>Burial</u></p>				<p>22b. DATE THEREOF <u>July 31 1961</u></p>			
<p>22c. NAME OF CEMETERY OR CREMATORY <u>Arlington National</u></p>				<p>22d. LOCATION (City, town, or country) (State) <u>Arlington Virginia</u></p>			
<p>23. FUNERAL DIRECTOR <u>Francis G. Barber</u></p>				<p>24a. REC'D BY REGISTRAR <u>JUL 28 '61</u></p>			
<p>ADDRESS <u>Laytonsville, Md.</u></p>				<p>24b. REGISTRAR'S SIGNATURE <u>Arthur S. House</u></p>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 3 & 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

YR A15 (4)
15M 9/60

(M)

(I)

0228
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH
00223

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY CO.</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u> c. LENGTH OF STAY IN (b) <u>21 days</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u> d. STREET ADDRESS <u>4612 Fairfield Dr.</u>	
3. NAME OF DECEASED (Type or print) <u>Helen M</u> First Middle Last		DATE OF DEATH <u>July 6 19 61</u> Month Day Year	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>9/6/06</u> Yrs. Months Days
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Wash. D.C.</u>	
13. FATHER'S NAME <u>Udo Augustus Pestell</u>		14. MOTHER'S MAIDEN NAME <u>Mary Susan Carico</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service)		16. SOCIAL SECURITY NO. <u>54</u>	
17. INFORMANT <u>Daughter (Joan Moore) Same as above</u>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>METASTATIC CARCINOMA } LUNG</u> DUE TO (b) <u>PRIMARY CARCINOMA } BREAST</u> Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last. (c) <u>2 YR</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a).		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER.)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>JUNE 19 1961</u> to <u>JULY 6 1961</u> , that (I) (we) last saw the deceased alive on <u>JULY 6 1961</u> , and that death occurred at <u>6:35</u> A.M. from the causes and on the date stated above.			
22a. SIGNATURE <u>[Signature]</u>		22b. DATE SIGNED <u>7/6/61</u>	
22c. PHYSICIAN'S NAME (Type) <u>LEW I DONOVAN MD</u>		22d. ADDRESS <u>8218-WISCONSIN AVE BETHESDA MD</u>	
23a. BURIAL, CREMATION, 23b. DATE THEREOF REMOVAL (Specify) <u>Cremation 7-9-61</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Lees Crematory</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>J. W. Lees</u>		25a. RECEIVED BY REGISTRAR <u>JUL 10 61</u> DATE	
25b. REGISTRAR'S SIGNATURE <u>Cuthbert L. Evans</u>		25c. LOCATION (City, town or county) (State) <u>Wash. D.C.</u>	

8228
 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
 CERTIFICATE OF DEATH

Reg. Dist. No. 0000

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chevy Chase				c. LENGTH OF STAY IN 1b 54			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 7312 Maple Avenue				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First William Middle Nelson Last Moore				4. DATE OF DEATH Month July Day 31 Year 19 61			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 18, 1865	9. AGE (In years last birthday) yrs 95	IF UNDER 1 YEAR Months 1 Days 1 Hours 1 Min. 1		IF UNDER 24 HRS. Hours 1 Min. 1
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Pat. Attorney		10b. KIND OF BUSINESS OR INDUSTRY Attorney		11. BIRTHPLACE (State or foreign country) Washington D. C.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Jsoeph Moore				14. MOTHER'S MAIDEN NAME Amelia Pretzkyman			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Ruth M Camp-Daughter-same 2d			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 42-0-1 DUE TO Acute myocardial infarction Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerotic Cardiovascular Disease DUE TO 15 yrs (c)						INTERVAL BETWEEN ONSET AND DEATH 1 day	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Pulmonary emphysema, severe						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from SEPT. 1939 to JULY 5, 1961 , that I last saw the deceased alive on JULY 5, 1961 , and that death occurred at 430 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED 7/31/61							
ACTUAL SIGNATURE Stephen W. DeJter M.D.				PHYSICIAN'S NAME (Type) STEPHEN W. DEJTER, M.D. 6719 WILSON LANE, BETHESDA 14, MD			
22a. BURIAL, CREMATION, REMOVAL (Specify) Cremation 8/2/61		22b. DATE THEREOF 8/2/61		22c. NAME OF CEMETERY OR CREMATORY Cedar Hill Crematory		22d. LOCATION (City, town, or county) (State) Suitland, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey				24a. REC'D BY REGISTRAR Bethesda, Maryland		24b. REGISTRAR'S SIGNATURE August 2 '61	



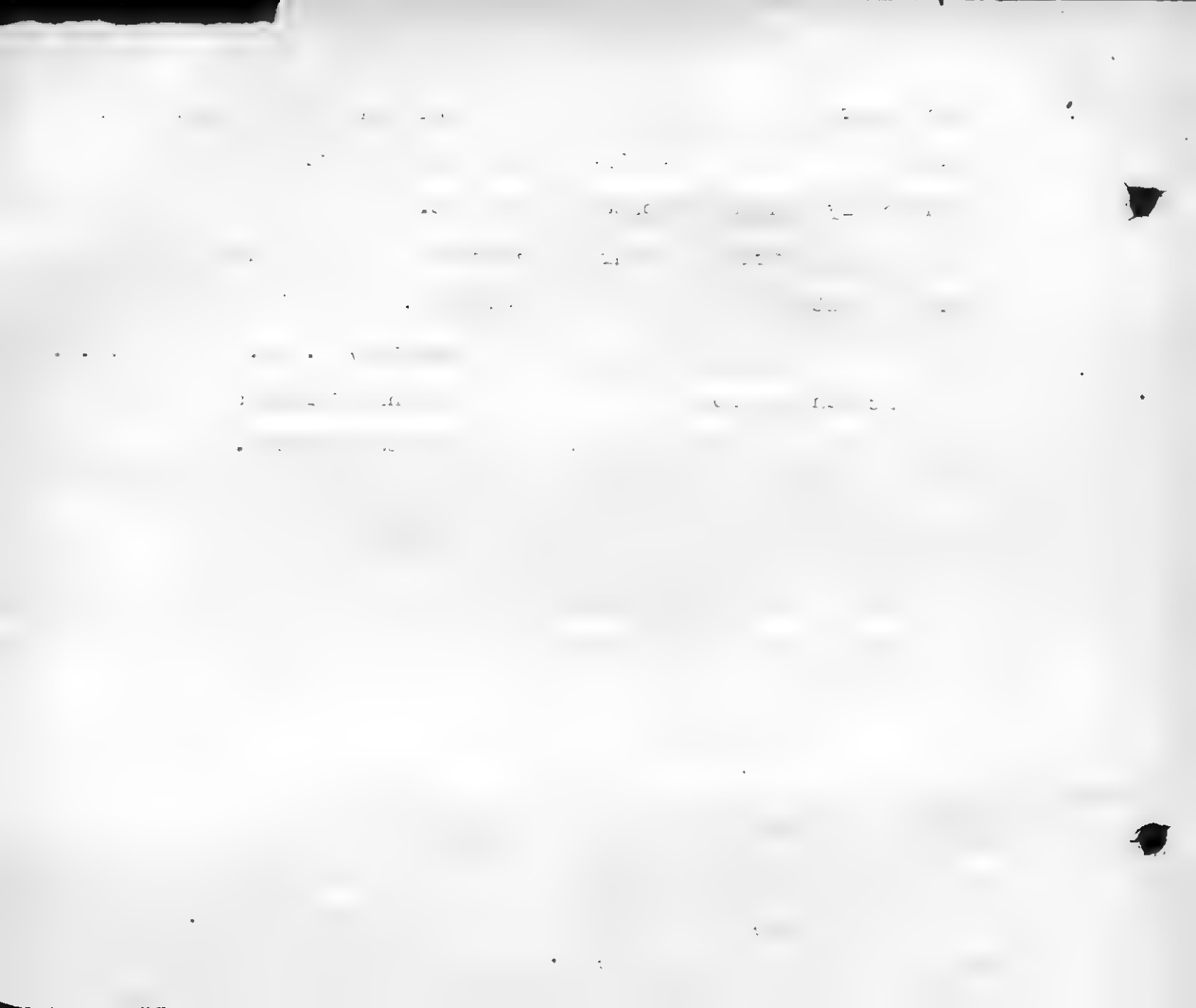
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

8230

08225

1 PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2 USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Olney				c. LENGTH OF STAY IN 1b 3 Days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Gaithersburg	
d. NAME OF HOSPITAL (If not in hospital, give street address) Montgomery General Hospital				d. STREET ADDRESS Rt. 1		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First Charles Middle Henry Last Musgrove				4. DATE OF DEATH Month July Day 13 Year 19 61			
5 SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1/19/1888		9 AGE (In years last birthday) 73 yrs	IF UNDER 1 YEAR: Months 73 Days 13 Hours 19 Min 61	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY Farm		11 BIRTHPLACE (State or foreign country) Maryland, U.S.A.		12 CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Steven Musgrove				14 MOTHER'S MAIDEN NAME Virginia Phillips			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO (If yes, give war or dates of service) 219-14-6002		17 INFORMANT Address Hospital Records,			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) CORONARY ARTERY OCCLUSION WITH MYOCARDIAL INFARCTION DUE TO 420.1 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) ARTERIOSCLEROTIC HEART DISEASE DUE TO (c) HYPERTENSION							INTERVAL BETWEEN ONSET AND DEATH 60 hours 5 years 10 am
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) General arteriosclerosis							19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21 I certify that (I) (this hospital) attended the deceased from 2/13 1961 to 7/13 1961 , that (I) (we) last saw the deceased alive on 7/13 1961 , and that death occurred at 1:27 A M, from the causes and on the date stated above							
22a. SIGNATURE G.F.M. EADORS MD				ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) G.F.M. EADORS MD				22d. ADDRESS DAMASCUS, MARYLAND			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF July 15, 1961		23c. NAME OF CEMETERY OR CREMATORY Clarksburg		23d. LOCATION (City, town, or county) (State) Clarksburg, Md.	
24 FUNERAL DIRECTOR'S SIGNATURE Francis H. Barber				ADDRESS Laytonsville, Md.		25a. REC'D BY REGISTRAR DATE JUL 17 '61	
				25b. REGISTRAR'S SIGNATURE James E. Finner			

MEDICAL CERTIFICATION



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 may be retained by the hospital or attending physician. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
ISM 9/60

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
2231
08226
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Takoma Park, c. LENGTH OF STAY N 1 B MARYLAND d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Washington Sanitarium and Hospital		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Montgomery c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Kensington, d. STREET ADDRESS 3210 Blueford Road,		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Infant Ann		4. DATE OF DEATH July 26, Last Month Day 19 61		9. AGE (In years last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. yrs. Months Days Hours Min. 1 20			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> B. DATE OF BIRTH July 26, 1961			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) no		10b. KIND OF BUSINESS OR INDUSTRY no		11. BIRTHPLACE (Country & State or foreign country) Maryland			
13. FATHER'S NAME Thomas Joseph Nochera		14. MOTHER'S M A D E N NAME Eleanor Flora Gammons		12. CITIZEN OF WHAT COUNTRY? America			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		16. SOCIAL SECURITY NO. no		17. INFORMANT mother			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Due to heart failure DUE TO Condition if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) no						INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) (IF EITHER, NOTIFY MEDICAL EXAMINER)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20c. TIME OF INJURY Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 10620 Georgia Ave., Silver Spring, Md.		20f. (City or town) (County) (State) Silver Spring Maryland	
21. I certify that (I) (this hospital) attended the deceased from July 26, 1961 , to July 26, 1961 , that (I) (we) last saw the deceased alive on July 26, 1961 , and that death occurred at 3:30 A.M. , from the causes and on the date stated above.						22b. DATE SIGNED 7-26-61	
22a. SIGNATURE Michael M. Dobridge, M. D.		22c. PHYSICIAN'S NAME (Type) Michael M. Dobridge, M. D.		22d. ADDRESS 10620 Georgia Ave., Silver Spring, Md.		22e. ADDRESS Bethesda, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF July 29, 1961		23c. NAME OF CEMETERY OR CREMATORY Gate of Heaven		23d. LOCATION (City, town or county) (State) Silver Spring Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE Arthur G. K... ..		25a. REC'D BY REGISTRAR UL 31 '61		25b. REGISTRAR'S SIGNATURE Arthur G. K...			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
8232
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>BETHESDA</u> c. LENGTH OF STAY IN It <u>5-6</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>SUBURBAN</u>		2. USUAL RESIDENCE (Where deceased lived, if institutions; Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>MONTGOMERY</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>BETHESDA, MARYLAND</u> d. STREET ADDRESS <u>4423 Rosehill Avenue</u>	
3. NAME OF DECEASED (Type or print) <u>Jessie Eva Cares</u>		4. DATE OF DEATH <u>10 PM</u> Month <u>JULY</u> Day <u>11</u> Year <u>1961</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct 5 1900</u>
9. AGE (In years, est. b. day) <u>60</u> yrs.		IF UNDER 1 YEAR Months <u>5</u> Days <u>10</u>	IF UNDER 24 HRS. Hours <u>10</u> Min. <u>PM</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>CLERK</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>PLUMBING</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Orange County Va.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>THOMAS MASON</u>		14. MOTHER'S M.A.DEN NAME <u>ALICE BARNES</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>1-32-1132</u>	
17. INFORMANT <u>Daughter</u>		Address <u>1321 Ave.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiovascular collapse</u> 175.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>generalized carcinomatous</u> DUE TO (c) <u>ovarian carcinoma</u>		INTERVAL BETWEEN ONSET AND DEATH <u>5 months</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour <u>am.</u> <u>19</u> p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>Feb</u> 19 <u>57</u> to <u>July 10</u> 19 <u>61</u> , that (U) (we) last saw the deceased alive on <u>July 10</u> 19 <u>61</u> , and that death occurred at <u>10:30 PM</u> , from the causes and on the date stated above.			
22a. SIGNATURE <u>Wilfred R. Ehirmantraut</u>		22b. DATE SIGNED <u>7/10/61</u>	
22c. PHYSICIAN'S NAME (Type or print) <u>Wilfred R. Ehirmantraut</u>		22d. ADDRESS <u>4890 Battery Lane Bethesda Md</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>7/14/61</u>	23c. NAME OF CEMETERY OR CREMATORY <u>New Hope Cemetery</u>	
23d. LOCATION (City, town or county) <u>Goldale</u>		(State) <u>Va.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>James A. ...</u>		25a. REC'D BY REGISTRAR <u>DATE JUL 13 '61</u>	
ADDRESS <u>...</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. ...</u>	



FOR STATE
HEALTH DEPT.

TO DEPT. OF MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If a day is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 9 60

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

8223

1. PLACE OF DEATH
a. COUNTY Montgomery MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Ashtown
c. LENGTH OF STAY IN lb 9 yrs
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Ind R-108

2. USUAL RESIDENCE (Where deceased lived, if Institution; Residence before admission)
a. STATE md b. COUNTY Montg
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Ashtown
d. STREET ADDRESS Ind R-108
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) Ray Leander Olson
4. DATE OF DEATH July 28 1961
5. SEX Male 6. COLOR OR RACE White 7. MARRIED ☒ NEVER MARRIED ☐ 8. DATE OF BIRTH 4-3-1882 9. AGE (In years last birthday) 79 yrs. 10. IF UNDER 1 YEAR Months 3 Days 25 11. IF UNDER 24 HRS. Hours 4 Min. 56

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Eng. 10b. KIND OF BUSINESS OR INDUSTRY Tel. Co. 11. BIRTHPLACE (State or foreign country) Wes. 12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME John C. Olson 14. MOTHER'S MAIDEN NAME Amelia Wilson
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No 16. SOCIAL SECURITY NO. R.L. Olson Jr. 17. INFORMANT John Address Ashtown

18. CAUSE OF DEATH (Enter on y one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) Acute congestive heart failure
521.1 DUE TO Emphysema (b)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c)
DUE TO
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH. 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐ Inspection ☒ Inquiry ☒ and in my opinion death resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☐ DEPUTY MEDICAL EXAMINER ☒ DATE SIGNED 7-28-61
ACTUAL SIGNATURE Frank J. Bruschat M.D. EXAMINER'S NAME (Type) FRANK J. BRUSCHAT Address (Street, city, town, or county) Rockville Maryland

22a. BURIAL CREMATION REMOVAL (Specify) Burial 22b. DATE THEREOF 7/31/1961 22c. NAME OF CEMETERY OR CREMATORY Parklawn 22d. LOCATION (City, town, or country) (State) Rockville Maryland

23. FUNERAL DIRECTOR Robert A. Pumphrey ADDRESS Bethesda, Maryland 24a. REC'D BY REGISTRAR JUL 31 '61 24b. REGISTRAR'S SIGNATURE Arthur L. Evans

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

8234

08223

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u> c. LENGTH OF STAY IN 1b <u>2 1/2</u> days d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Suburban Hospital</u>		2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u> d. STREET ADDRESS <u>5735 Bradley Blvd.</u>		15. RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Joseph P. Pappano</u> First Middle Last		4. DATE OF DEATH <u>July 10 1961</u> Month Day Year		9. AGE (In years if under 1 year, if under 24 hrs. last birthday) <u>87</u> yrs. Months Days Hours Min.	
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, or retired) <u>Retired -Proprietor- Tailor Shop</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Italy</u>		11. BIRTHPLACE (Country & State or foreign country) <u>Italy</u>	
13. FATHER'S NAME <u>Antonio Pappano</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>		12. CITIZEN OF WHAT COUNTRY? <u>Naturalized. U.S.A. 60 years</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO <u>Unknown</u>		17. INFORMANT <u>Daughter Miss Clea Pappano - same as above</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Myocardial Infarction</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>3 days</u> (a), stating the underlying cause last. (c) <u>3 days</u> DUE TO		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a).					
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		20g. (County)		20h. (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>3/27</u> 19<u>57</u> to <u>7/10</u> 19<u>61</u>, that (I) <u>was</u> last saw the deceased alive on <u>7/10</u> 19<u>61</u>, and that death occurred at <u>1:30</u> A.M. from the causes and on the date stated above.					
22a. SIGNATURE <u>John E. Everett</u>		22b. DATE SIGNED <u>7-10-61</u>		22c. PHYSICIAN'S NAME (Type) <u>JOHN E. EVERETT</u>	
22d. ADDRESS <u>9400 Conn. Ave. Kensington</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>7-12-61</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Gate of Heaven</u>	
23d. LOCATION (City, town or county) <u>Montgomery County, Md.</u>		23e. ADDRESS <u>Bethesda, Md.</u>			
24. FUNERAL DIRECTOR'S SIGNATURE <u>ROBERT A. PUMPHREY</u>		25a. REC'D BY REGISTRAR <u>DATE JUL 13 '61</u>			
25b. REGISTRAR'S SIGNATURE <u>Arthur L. Harris</u>					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 3 & 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

8235

1. PLACE OF DEATH
a. COUNTY Montgomery
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Takoma Park
c. LENGTH OF STAY IN 1b MARYLAND
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Washington Sanitarium and Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)
a. STATE Maryland
b. COUNTY Prince George
c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Hyattsville
d. STREET ADDRESS 3503-57th Ave nue

3. NAME OF DECEASED (Type or print) Walter Robert Parsons

4. DATE OF DEATH July 14 1961

5. SEX Male

6. COLOR OR RACE White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH February 10, 1899

9. AGE (in years last birthday) 62 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Plumbing Inspector

11. BIRTHPLACE (County & State, or foreign country) District of Columbia

12. CITIZEN OF WHAT COUNTRY? U.S.A

13. FATHER'S NAME James H. Parsons

14. MOTHER'S MAIDEN NAME Caroline Grimm

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) yes WWI Navy

16. SOCIAL SECURITY NO. Washington Sanitarium and Hospital Records

17. INFORMANT Address

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) Myocardial Infarction, Acute, Left Anterior-Lateral
CORONARY occlusion, Acute, Left Anterior descending
DUE TO (b) 3 w. Ks.
DUE TO (c) 3 w. Ks.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER).
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from June 18, 1961 to July 14, 1961, that (I) (we) last saw the deceased alive on July 13, 1961, and that death occurred at 6:30 AM, from the causes and on the date stated above.

22a. SIGNATURE Raymond C. West

22b. DATE SIGNED July 17, 1961

22c. PHYSICIAN'S NAME (Type) Raymond C. West

22d. ADDRESS 300 H. St. N.E.

23a. BURIAL, CREMATION, or REMOVAL (Specify) 7/17/61

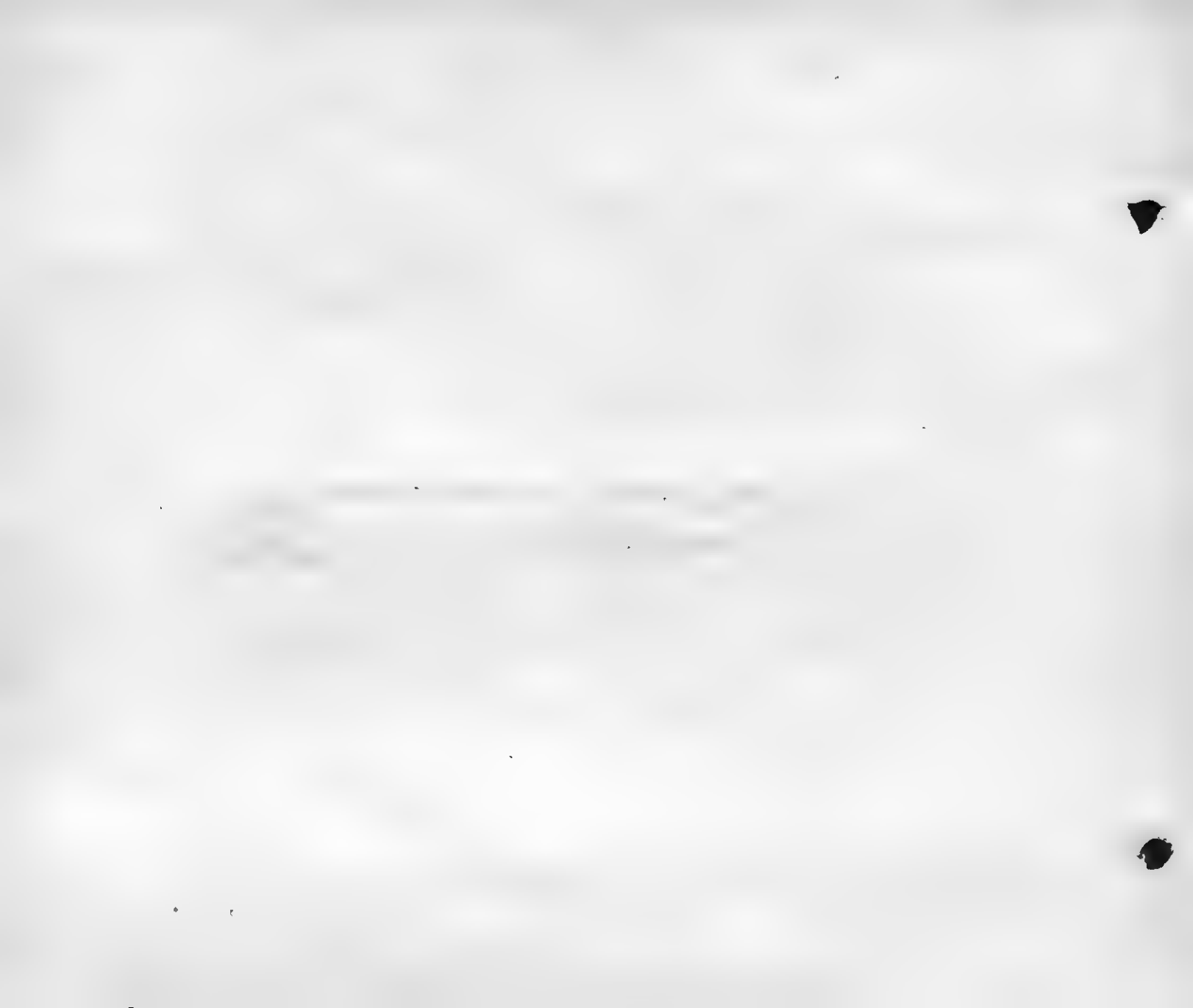
23b. NAME OF CEMETERY OR CREMATORY Cedar Hill

23c. LOCATION (City, town or county) (State) Suitland, Md.

24. FUNERAL DIRECTOR'S SIGNATURE J. M. Lee

25a. REC'D BY REGISTRAR JUL 17 '61

25b. REGISTRAR'S SIGNATURE Arthur L. Hume



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, read in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

8236

08231

1. PLACE OF DEATH a. COUNTY Montgomery		2. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) a. STATE South Carolina	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)		b. COUNTY South Carolina	
c. LENGTH OF STAY IN 1b 9 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Beaufort	
3. NAME OF DECEASED (Type or print) U. S. Naval Hospital		d. STREET ADDRESS Box 989	
4. DATE OF DEATH July 31 1961		a. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
5. SEX Male		6. COLOR OR RACE Caucasian	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 2-11-98	
9. AGE (In years last birthday) 63 yrs.		10. IF UNDER 1 YEAR Months 7 Days 7 Hours 7 Min. 7	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Officer		10b. KIND OF BUSINESS OR INDUSTRY USMC	
11. BIRTHPLACE (County & State or foreign country) South Carolina		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME McCall Pate		14. MOTHER'S MAIDEN NAME Ann Cornick	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) Yes WWII		16. SOCIAL SECURITY NO Mary E. Pate Same as #2 above	
17. INFORMATION Mary E. Pate Same as #2 above		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of pancreas with metastases DUE TO 1-7-7 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, 1-7-7 DUE TO 1-7-7 PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 1-7-7		INTERVAL BETWEEN ONSET AND DEATH 2 months	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part I of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (this hospital) attended the deceased from July 22 to July 31, 1961 , that (we) last saw the deceased alive on July 31, 1961 , and that death occurred at 10:10 PM from the causes and on the date stated above.		22b. DATE SIGNED August 1, 1961	
22a. SIGNATURE G. I. Walker, Jr.		22c. PHYSICIAN'S NAME (Type) G. I. WALKER, JR., CAPTAIN MC USN	
22d. ADDRESS U. S. Naval Hospital, Bethesda, Md.		22e. REC'D BY REGISTRAR August 1, 1961	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF August 3, 1961	
23c. NAME OF CEMETERY OR CREMATORY Arlington National		23d. LOCATION (City, town or county) (State) Arlington Va.	
24. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey		25. REC'D BY REGISTRAR August 3 '61	
25b. REGISTRAR'S SIGNATURE Robert A. Pumphrey		25c. REGISTRAR'S SIGNATURE Robert A. Pumphrey	



TO HOSPITAL: The low requires that the death certificate be executed within 24 hours after death. Page 4
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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
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MARYLAND STATE DEPARTMENT OF HEALTH

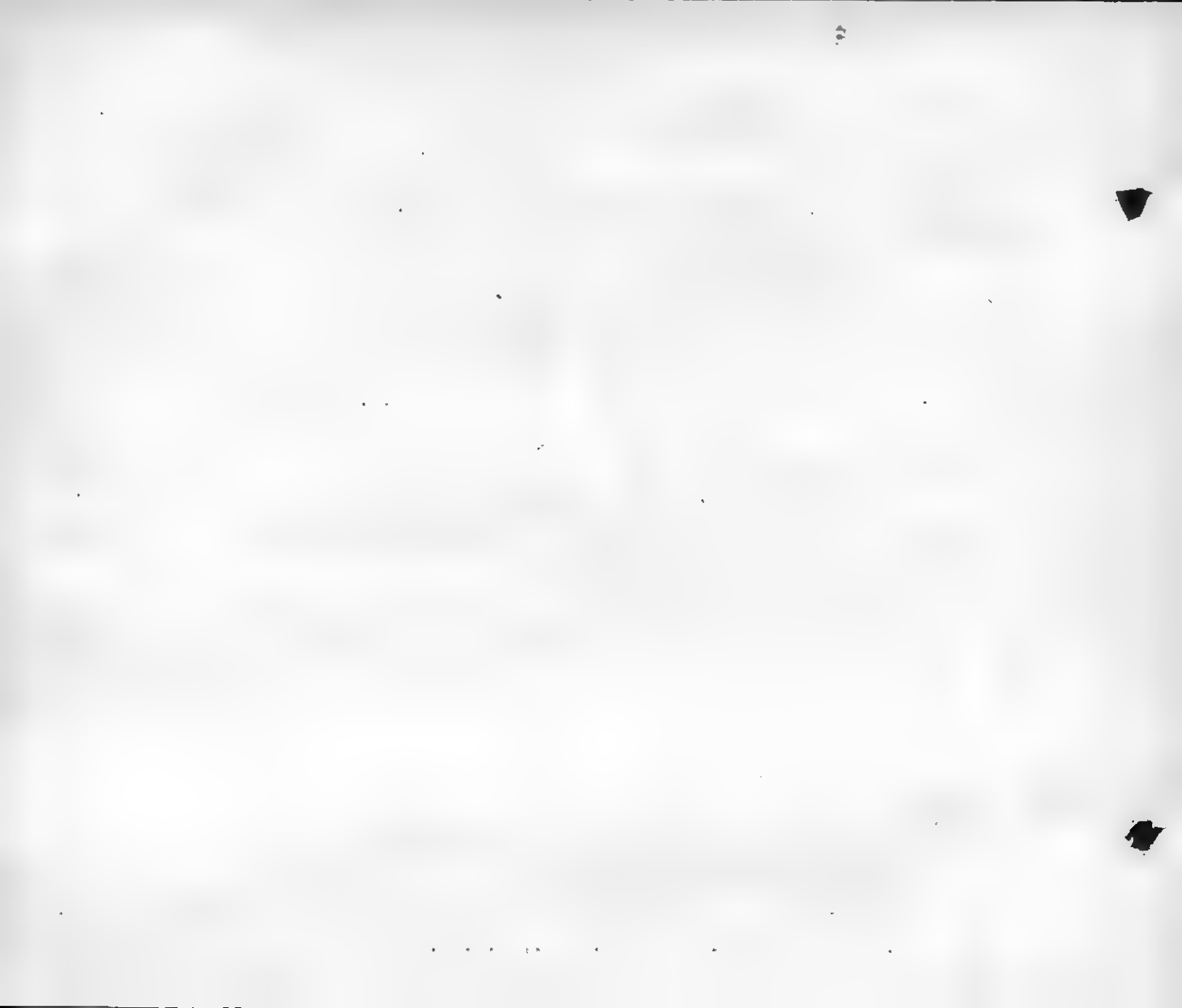
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

8237

08232

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MD. b. COUNTY MONTGOMERY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING 29	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 1303 BALLARD STREET		d. STREET ADDRESS 1303 BALLARD STREET	
3. NAME OF DECEASED (Type or print) First Middle Last ROBERT HARRIS PEMBERTON		4. DATE OF DEATH Month Day Year JULY 6 1961	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH JULY 1, 1909
9. AGE (In years last birthday) 52 yrs		10. IF UNDER 1 YEAR Months Days Hours Min. 0 5	
11a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) SUPERVISOR		11b. KIND OF BUSINESS OR INDUSTRY Potomac Electric Power	
11c. BIRTHPLACE (State or foreign country) Zanesville, Ohio		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Oecil R. Pemberton		14. MOTHER'S MAIDEN NAME Jeanette F. Parthesius	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO 577 09 3712	
17. INFORMANT Address MRS. R.H. PEMBERTON AS ABOVE.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 201 ACUTE CORONARY OCCLUSION DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) CORONARY ATHEROSCLEROSIS DUE TO (c) 54 YEARS		INTERVAL BETWEEN ONSET AND DEATH 2 HOURS	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a):		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month Day Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from JULY 6 1961 to JULY 6 1961 , that (I) (we) last saw the deceased alive on JULY 6 1961 , and that death occurred at 10:28 PM , from the causes and on the date stated above.			
22a. SIGNATURE James A. Roberts M.D.		22b. DATE SIGNED JULY 6, 1961	
22c. PHYSICIAN'S NAME (Type) JAMES A. ROBERTS		22d. ADDRESS 8907 GEORGIA AVE SILVER SPRING, MD.	
23a. BURIAL, CREMATION, REMOVAL (Specify) XXXXXXX		23b. DATE THEREOF 7-10-61	
23c. NAME OF CEMETERY OR CREMATORY George Washington Memorial		23d. LOCATION (City, town, or county) (State) Prince Georges Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Warner E. Humphrey, Inc. ADDRESS 8434 Ga. Ave., S.S.Md.		25a. REC'D BY REGISTRAR DATE JUL 11 61	
25b. REGISTRAR'S SIGNATURE William S. Hanna			



8238

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

8233

1 PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a STATE <u>md.</u> b COUNTY <u>Mont.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>51 Chevy Chase</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban Hospital</u>		d. STREET ADDRESS <u>3707 Spring St.</u>	
3. NAME OF DECEASED (Type or print) First <u>Edward</u> Middle <u>E</u> Last <u>Perry</u>		4. DATE OF DEATH Month <u>July</u> Day <u>19</u> Year <u>1961</u>	
5 SEX <u>male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept. 19, 1885</u>
9. AGE (In years last birthday) <u>75</u> yrs		IF UNDER 1 YEAR Months <u></u> Days <u></u> Hours <u></u> Min <u></u>	IF UNDER 24 HRS. Hours <u></u> Min <u></u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired stationary engineer</u>		11. BIRTHPLACE (State or foreign country) <u>New York</u>	
12. CITIZEN OF WHAT COUNTRY <u>U. S. A.</u>			
13. FATHER'S NAME <u>Nelson Perry</u>		14. MOTHER'S MAIDEN NAME <u>Rachael King</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>578-03-7542</u>	
17. INFORMANT <u>Edward J. (son)</u>		Address <u>Same</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary thrombosis</u> 1201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Coronary Atherosclerosis</u> DUE TO (c) <u></u>			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m. <u></u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>6/5/1953</u> to <u>7/19/1961</u> , that (I) (we) last saw the deceased alive on <u>6/5/1961</u> , and that death occurred at <u>10:00</u> M, from the causes and on the date stated above			
22a. SIGNATURE <u>W. T. Joyce</u> M. D.		ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>	
22c. PHYSICIAN'S NAME (Type) <u>William T. Joyce</u>		22d. ADDRESS <u>8106 Maple Ridge Rd, Bethesda, Md.</u>	
23a. BURIAL, CREMATION, OR REMOVAL (Specify) <u>7/21/61</u>		23b. DATE THEREOF	
23c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>Pr. Geo. Co., Maryland</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>The S.H.Hines Co., 2901 14th St. N.W.</u>		ADDRESS <u>Wash, D.C.</u>	
25a. REC'D BY REGISTRAR <u>JUL 21 '61</u>		25b. REGISTRAR'S SIGNATURE <u>Charles S. Hines</u>	

(M)

(1)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 3 and 4 may be retained by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

8239

08234

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u> c. LENGTH OF STAY IN 1b <u>1 1/2 days</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Suburban</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u> d. STREET ADDRESS <u>1909 Colesville Beltsville Rd</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Susie</u> First Middle Last 4. DATE OF DEATH <u>July 23 1961</u> Month Day Year		5. SEX <u>Female</u> 6. COLOR OR RACE <u>Col.</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH <u>October 8 1883</u> Month Day Year	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u> 10b. KIND OF BUSINESS OR INDUSTRY 11. BIRTHPLACE (County & State, or foreign country) <u>VIRGINIA</u> 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>Samuel Hill</u> 14. MOTHER'S MAIDEN NAME <u>MARIA</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>-</u> 16. SOCIAL SECURITY NO. <u>-</u> 17. INFORMANT <u>(Mary Young) same as above</u> Address <u>-</u>		18. CAUSE OF DEATH (Enter only one cause per line, or (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Stroke</u> DUE TO <u>arteriosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>hypertension</u> DUE TO <u>hypertension</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Congestive Heart Failure</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20c. TIME OF INJURY Month, Day, Year <u>July 23 1961</u> Hour a.m. p.m. <u>19</u> 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u> 20f. (City or town) (County) (State) <u>Frederick, Md.</u>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> INTERVAL BETWEEN ONSET AND DEATH <u>1 1/2 days</u>	
21. I certify that (I) (this hospital) attended the deceased from <u>July 23 1961</u> to <u>July 23 1961</u> , that (I) (we) last saw the deceased alive on <u>July 23 1961</u> , and that death occurred at <u>11 A.M.</u> from the causes and on the date stated above. 22a. SIGNATURE <u>[Signature]</u> 22c. PHYSICIAN'S NAME (Type) <u>Robert L. Shneider</u>		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> 22d. ADDRESS <u>Rockville, Md.</u> 22b. DATE SIGNED <u>24 July 61</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> 23b. DATE THEREOF <u>7-28-61</u> 23c. NAME OF CEMETERY OR CREMATORY <u>Bright Hope</u> 23d. LOCATION (City, town or county) (State) <u>Frederick, Va.</u>		24. FUNERAL DIRECTOR'S SIGNATURE <u>Robert L. Shneider</u> 25a. REC'D BY REGISTRAR <u>AUG 2 '61</u> 25b. REGISTRAR'S SIGNATURE <u>Arthur S. Hanna</u>	

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

8240

08235

1 PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>TAKOMA PARK</u> c. LENGTH OF STAY IN 1b <u>32 hrs.</u> d. NAME OF HOSPITAL (If not a hospital, give street address) OR INSTITUTION <u>WASH. SANITARIUM AND HOSPITAL</u>				2 USUAL RESIDENCE (Where deceased lived If institution. Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY _____ c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HYATTSVILLE</u> d. STREET ADDRESS <u>8217 14th AVENUE</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
3. NAME OF DECEASED (Type or print) First Middle Last <u>JOSEPH (NONE) POLLOCK</u>				4. DATE OF DEATH Month Day Year <u>July 5 1961</u>											
5 SEX <u>MALE</u>		6 COLOR OR RACE <u>WHITE</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8 DATE OF BIRTH <u>2-24-88</u>		9. AGE (In years last birthday) <u>73</u> yrs IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.							
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RETIRED STOREKEEPER</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>NONE</u>		11. BIRTHPLACE (State or foreign country) <u>RUSSIA</u>		12 CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>ISRAEL POLLOCK</u>				14 MOTHER'S MAIDEN NAME <u>RACHEL GARBITZ</u>											
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>NO</u>				16 SOCIAL SECURITY NO. <u>77-483168</u>		17 INFORMANT Address <u>CHARIT, WASH. SANITARIUM + HOSP.</u>									
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>421.4</u> DUE TO <u>Distention of Left Lung</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Pulmonary Infarction</u> DUE TO <u>Subendocardial Myocardial Infarction</u> (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Myocardial Infarction</u> INTERVAL BETWEEN ONSET AND DEATH															
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/> YES <input type="checkbox"/> NO								20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) _____							
20c. TIME OF INJURY Month. Day. Year Hour a.m. p.m. _____ 19____				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____		20f. (City or town) (County) (State) _____							
21 I certify that (I) (this hospital) attended the deceased from <u>July 3 1961</u> to <u>July 5 1961</u> that (I) (we) last saw the deceased alive on <u>July 5 1961</u> and that death occurred at <u>3:30 PM</u> from the causes and on the date stated above															
22a. SIGNATURE <u>Boris Rabkin M.D.</u>						ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>7/5/61</u>							
22c. PHYSICIAN'S NAME (Type) <u>BORIS RABKIN</u>						22d. ADDRESS <u>1019 University Boulevard SE</u>									
23a. BURIAL CREMATION REMOVAL (Specify) <u>BURIAL</u>				23b. DATE THEREOF <u>7/7/61</u>		23c. NAME OF CEMETERY OR CREMATORY <u>NATL CAP. Hebrew</u>		23d. LOCATION (City, town, or country) <u>DC</u>							
24. FUNERAL DIRECTOR'S SIGNATURE <u>Goldberg Funeral Home</u>						ADDRESS <u>4717 9th Ave</u>		25a. REC'D BY REGISTRAR <u>DATE JUL 7 '61</u>							
25b. REGISTRAR'S SIGNATURE <u>William S. Kneass</u>															

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed with the funeral director, and in any event, within 72 hours after death. Pages 3 and 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1
FOR STATE
HEALTH DEPT.
TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If a day is necessary, give the day in the space provided. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
0824 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 08236

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>ROCKVILLE</u> c. LENGTH OF STAY IN 1b <u>3 1/2</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Suburban</u>		2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>WATERLOO</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>ROCKVILLE</u> d. STREET ADDRESS <u>500 E. 4th Ave.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Benjamin POOLE, Sr</u>	4. DATE OF DEATH <u>Aug 7 - 1961</u>	5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug. 30 1913</u>	9. AGE (In years last birthday) <u>47</u> yrs.	10. IF UNDER 1 YEAR Months Days 11. IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Printer</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>PRINTING</u>	11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13. FATHER'S NAME <u>John H POOLE</u>	14. MOTHER'S MAIDEN NAME <u>MARGARET KNOWN</u>	15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service)	16. SOCIAL SECURITY NO. <u>MYRTES POOLE-583-421-4</u>
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) <u>810X</u> DUE TO <u>Multiple Injuries, extreme</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (c) <u>3 1/2 hrs</u>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I a.			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. <u>Struck by train while driving car across RR crossing</u>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year <u>5:31 p.m. 7-18 19 61</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Acheson Crossing</u>	20f. (City or town) <u>Washington</u> (County) <u>Prince Georges</u> (State) <u>MD</u>
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from. Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Frank J. Broschart</u> EXAMINER'S NAME (Type) <u>FRANK J. BROSCHEART</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED <u>7-19-61</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>		22b. DATE THEREOF <u>7/22/61</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Parl'lar</u>
23. FUNERAL DIRECTOR <u>Lyson Wheeler</u> ADDRESS <u>1331 East Montague Rockville</u>		24a. REC'D BY REGISTRAR <u>DATE JUL 24 '61</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hines</u>

1
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

2242 00237

1. PLACE OF DEATH
a. COUNTY MONTGOMERY MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Takoma Park
c. LENGTH OF STAY IN lb 126
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Wash. Sen. Hosp

2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)
a. STATE Maryland b. COUNTY Prince George's
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hyattsville
d. STREET ADDRESS 4703 Ravenswood Rd

3. NAME OF DECEASED (Type or print) Leister, David
First Middle Last
4. DATE OF DEATH July 21 1961
Month Day Year
5. SEX M 6. COLOR OR RACE Wk 7. MARRIED ☐ NEVER MARRIED ☐ 8. DATE OF BIRTH 9-14-37
WIDOWED ☐ DIVORCED ☐ 9. AGE (In years last birthday) 23 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Line man 10b. KIND OF BUSINESS OR INDUSTRY Electric Co. 11. BIRTHPLACE (State or foreign country) Waynesboro, Va 12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME Arthur David Leister 14. MOTHER'S MAIDEN NAME Bertina May
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No 16. SOCIAL SECURITY NO. Mr. Wayne Leister (Bro) 17. INFORMANT Address
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Electrocution
9/4/61 DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒
20a. EXTERNAL CAUSE WAS PRIMARY ☒ OR CONTRIBUTING CAUSE OF DEATH. Fell from pole across live wire when digging hole
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month Day Year Hour min. 3:14 p.m. 7-21-61 20d. INJURY OCCURRED While ☒ Not while ☐ et work ☒ et work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Street 20f. (City or town) Silver Spring (County) Montgomery (State) Md
21. I certify that I took charge of the remains described above, held an Autopsy ☐ Inspection ☒ Inquiry ☒ and my opinion death resulted from: Natural causes ☐ Accident ☒ Suicide ☐ Homicide ☐ Undetermined manner ☐
ACTUAL SIGNATURE Frank J. Brosch CHIEF MEDICAL EXAMINER ☐ M D ASSISTANT MEDICAL EXAMINER ☐ DEPUTY MEDICAL EXAMINER ☒ DATE SIGNED 7-21-61
EXAMINER'S NAME (Type) FRANK J. Brosch Address (Street, city, town, or county) 7-21-61
22a. BURIAL, CREMATION, REMOVAL (Specify) Transportation 22b. DATE THEREOF 7/23/61 22c. NAME OF CEMETERY OR CREMATORY Waynesboro 22d. LOCATION (City, town, or country) (State) Virginia
23. FUNERAL DIRECTOR G. Gasch's Sons ADDRESS Hyattsville, Md. 24a. REC'D BY REGISTRAR JUL 26 '61 24b. REGISTRAR'S SIGNATURE Arthur S. Kline

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be retained by the hospital or attending physician. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u> c. LENGTH OF STAY IN b. <u>43</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Suburban Hospital</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>43 Kensington, 50</u> d. STREET ADDRESS <u>14535 Everett Street</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Leonard John</u> First Middle Last 4. SEX <u>male</u> 5. COLOR OR RACE <u>white</u> 6. MARIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> 7. DATE OF BIRTH <u>July 8, 1961</u> 8. DATE OF DEATH <u>July 9, 1961</u> 9. AGE (In years last birthday) <u>0</u> yrs. 10. IF UNDER 1 YEAR Months <u>6</u> Days <u>29</u> 11. IF UNDER 24 HRS. Hours <u>6</u> Min. <u>29</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>mother</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>mother</u> 11. BIRTHPLACE, County & State, or foreign country <u>Montgomery, Maryland</u> 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		14. MOTHER'S MAIDEN NAME <u>Rosalyn Louise Schmidlin</u> Address <u>4535 Everett St, Kensington, Md</u>	
13. FATHER'S NAME <u>Leonard John Quill</u> 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>no</u> 16. SOCIAL SECURITY NO. <u>776X</u> 17. INFORMANT <u>mother</u>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>PREMATURITY</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>776X</u> (b) <u>DUE TO</u> (c) <u>DUE TO</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>INTERVAL BETWEEN ONSET AND DEATH</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u> 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)		21. I certify that (I) (this hospital) attended the deceased from <u>7-8</u> , 19 <u>61</u> to <u>7-8</u> , 19 <u>61</u> , that (I) (we) last saw the deceased alive on <u>7-7</u> , 19 <u>61</u> , and that death occurred at <u>8:30</u> AM, from the causes and on the date stated above.	
22a. SIGNATURE <u>John E. Cassidy M.D.</u> 22c. PHYSICIAN'S NAME (Type) <u>JOHN E. CASSIDY, M.D.</u> 22b. DATE SIGNED <u>7-8-61</u>		22d. ADDRESS <u>9911 Old Georgetown Rd. MARYLAND</u>	
23a. BURIAL, CREMATION REMOVAL (Specify) <u>Burial-transit</u> 23b. DATE THEREOF <u>7-11-61</u> 23c. NAME OF CEMETERY OR CREMATORY <u>Holy Cross Cemetery</u> 23d. LOCATION (City, town or county) (State) <u>Indianapolis, Indiana</u>		24. FUNERAL DIRECTOR'S SIGNATURE <u>ROBERT A. PUMPHREY</u> ADDRESS <u>Bethesda, Md.</u> 25a. REC'D BY REG. STRAR <u>JUL 13 '61</u> 25b. REGISTRAR'S SIGNATURE <u>Charles S. Frank</u>	

ST 3.1

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

8244

08233

1 PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>FAIRLAND</u> c. LENGTH OF STAY IN 1b <u>5-13 61-7-2061</u> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>FAIRLAND NURSING HOME</u>				2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>MONT.</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SILVER SPRING</u> d. STREET ADDRESS <u>316 LADSON RD.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
3 NAME OF DECEASED (Type or print) First Middle Last <u>VACHEL WILLIAM RANDALL</u>				4 DATE OF DEATH Month Day Year <u>JULY 20 1961</u>											
5 SEX <u>MALE</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Sept 26 - 1886</u>		9. AGE (In years last birthday) yrs. <u>80</u>		IF UNDER 1 YEAR Months Days Hours Min		IF UNDER 24 HRS Hours Min			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>SALESMAN</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Jewelry Galt Bros.</u>				11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>				12. CITIZEN OF WHAT COUNTRY? <u>USA.</u>			
13. FATHER'S NAME <u>Worthington VACHEL</u>						14. MOTHER'S MAIDEN NAME <u>Susan RANDALL WYOM A WEST</u>									
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No None</u>				16. SOCIAL SECURITY NO <u>577-07-1775</u>				17. INFORMANT Address <u>Mrs. William Arthur Randall</u> <u>110 St. Lawrence Drive, Silver Spring, Maryland</u>							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Vascular Hemorrhage</u> <u>331X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Cerebral Arteriosclerosis</u> DUE TO (c) <u>3-4 yrs.</u>															
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>19 WAS AUTOPSY PERFORMED?</u> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>															
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)											
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)							
21. I certify that (I) (this hospital) attended the deceased from <u>May 1950</u> to <u>July 20, 1961</u> . that (I) (we) last saw the deceased alive on <u>July 5, 1961</u> and that death occurred at <u>6 AM</u> from the causes and on the date stated above															
22a. SIGNATURE <u>Robert B. Irey</u>						ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22b. DATE SIGNED <u>July 20, 1961</u>							
22c. PHYSICIAN'S NAME (Type) <u>ROBERT B. Irey</u>						22d. ADDRESS <u>7105 Riggs Rd, Hyattsville, Md</u>									
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				23b. DATE THEREOF <u>7/22/61</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Parklawn Cemetery</u>				23d. LOCATION (City, town, or county) (State) <u>Montgomery Maryland</u>					
24. FUNERAL DIRECTOR'S SIGNATURE <u>Warner E. Humphrey, Inc.</u>						25a. REC'D BY REGISTRAR <u>July 24 '61</u>						25b. REGISTRAR'S SIGNATURE <u>Arthur L. Thomas</u>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
ISM 9/60

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
8246
CERTIFICATE OF DEATH

09365

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Bethesda (Rural) c. LENGTH OF STAY IN b 1 day d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) U. S. Naval Hospital		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Bethesda c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Bethesda d. STREET ADDRESS 5908 Maiden Lane		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Sue First Middle Last Rhees 5. SEX Female 6. COLOR OR RACE Caucasian 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH 7-22-61 9. AGE (In years last birthday) yrs. Months Days 13 46 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) 10b. KIND OF BUSINESS OR INDUSTRY Bethesda, Maryland 11. BIRTHPLACE (County & State, or foreign country) USA 12. CITIZEN OF WHAT COUNTRY? USA		4. DATE OF DEATH July 23 1961 Month Day Year 13. FATHER'S NAME Thomas R. Rhees 14. MOTHER'S MAIDEN NAME Caroline West 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) No 16. SOCIAL SECURITY NO. 17. INFORMANT Thomas R. Rhees Same as # 2 Above Address		18. CAUSE OF DEATH (Enter on only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Prematurity DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a). 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) 20g. (City or town) (County) (State) 20h. (City or town) (County) (State)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21. I certify that (X) (this hospital) attended the deceased from July 22, 1961 to July 23, 1961, that (X) (we) last saw the deceased alive on July 23, 1961, and that death occurred at 2:30 AM, from the causes and on the date stated above.							
22a. SIGNATURE Robert V. Rack 22c. PHYSICIAN'S NAME (Type) ROBERT V. RACK, LT MC USN		22b. DATE SIGNED July 24, 1961 22d. ADDRESS U. S. Naval Hospital, Bethesda, Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify) Cremation-Springmont		23b. DATE THEREOF July 25, 1961		23c. NAME OF CEMETERY OR CREMATORY Fort Lincoln			
24. FUNERAL DIRECTOR'S SIGNATURE Tyson Wheeler Rockville, Md.		25a. REC'D BY REGISTRAR DATE JUL 26 '61		25b. REGISTRAR'S SIGNATURE William S. Evans			

-2.15136.3XV

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
8247
CERTIFICATE OF DEATH

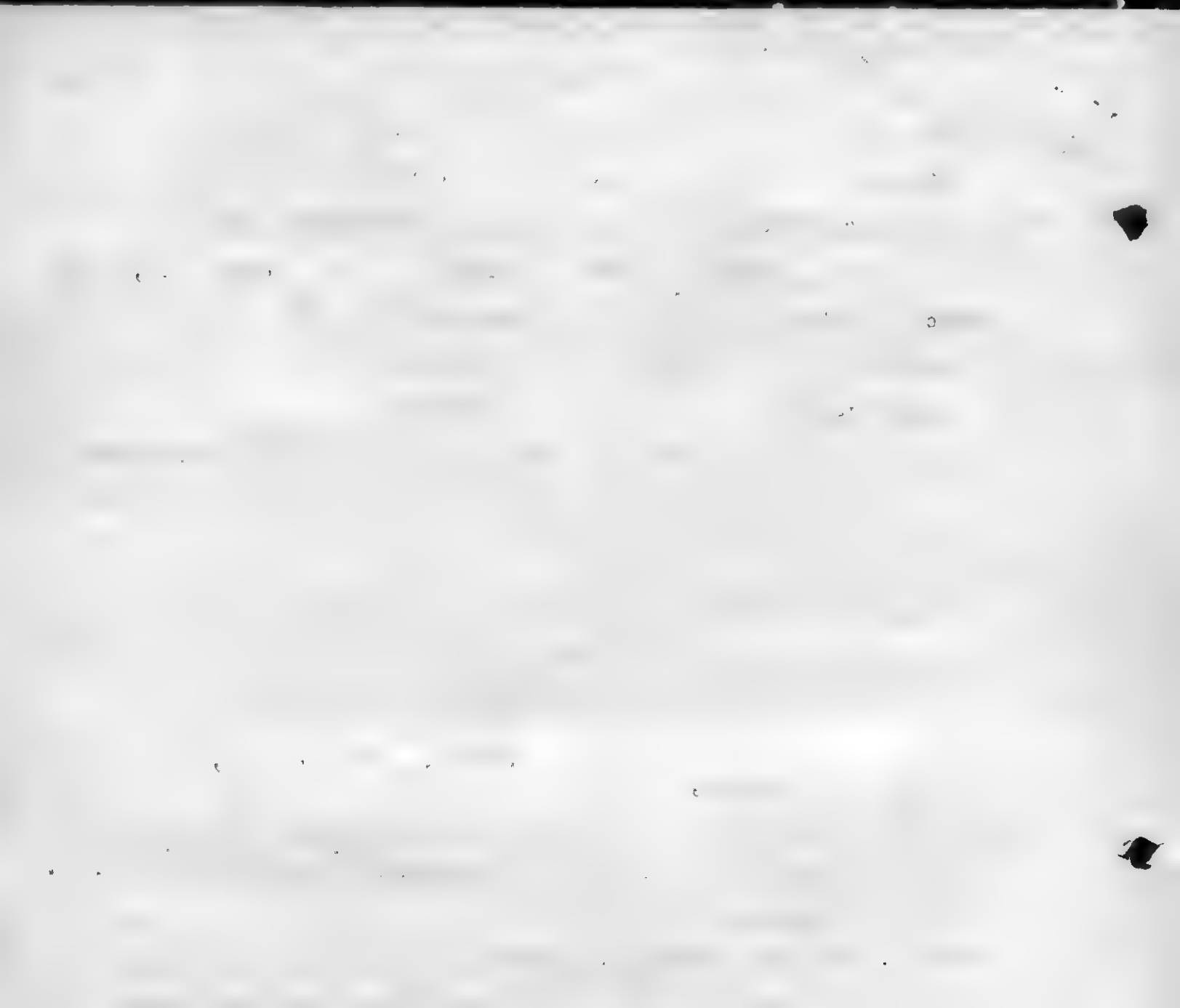
1. PLACE OF DEATH a. COUNTY Montgomery		b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)		c. LENGTH OF STAY IN It 2 days		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) e. STATE Maryland		b. COUNTY 1	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) U. S. Naval Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		d. STREET ADDRESS 5908 Maiden Lane		f. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Thomas		Middle Rhees		Last Rhees		4. DATE OF DEATH Month July		Day 24	
5. SEX Male		6. CO. OR RACE Caucasian		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 7-22-61		9. AGE (In years last birthday) yrs. 2	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) Bethesda, Maryland		12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME Thomas R. Rhees		14. MOTHER'S MAIDEN NAME Caroline West		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) No		16. SOCIAL SECURITY NO. Thomas R. Rhees Same as # 2 above		17. INFORMANT Address Thomas R. Rhees Same as # 2 above	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Prematurity 7/25/61 DUE TO Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a). Erythroblastosis fetalis (Rh)		INTERVAL BETWEEN ONSET AND DEATH		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) July 22, 1961 to July 24, 1961		20g. (County) Prince Georges County, Md.		20h. (State) Md.		21. I certify that (X) (this hospital) attended the deceased from July 22, 1961 to July 24, 1961, that (X) (we) last saw the deceased alive on July 24, 1961, and that death occurred at 1:56 AM, from the causes and on the date stated above.		22a. SIGNATURE Robert V. Rack M.D.	
22b. DATE July 24, 1961		22c. PHYSICIAN'S NAME (Type) ROBERT V. RACK, LT MC USN		22d. ADDRESS U. S. Naval Hospital, Bethesda, Md.		22e. REC'D BY REGISTRAR JUL 26 '61		22f. REGISTRAR'S SIGNATURE Arthur S. Thoma	
23a. BURIAL, CREMATION, REMOVAL (Specify) Cremation - Springfield		23b. DATE THEREOF July 25, 1961		23c. NAME OF CEMETERY OR CREMATORY Fort Lincoln		23d. LOCATION (City, town or county) Prince Georges County, Md.		23e. (State) Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Tyson Wheeler		24a. ADDRESS Rockville, Md.		24b. DATE JUL 26 '61		24c. REGISTRAR'S SIGNATURE Arthur S. Thoma		24d. DATE JUL 26 '61	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 4 may be retained by the hospital or attending physician. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

8245
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda c. LENGTH OF STAY IN town 28 Days d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) The Clinical Center		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Florida b. COUNTY Jacksonville c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Jacksonville d. STREET ADDRESS 4765 Riverdale Road	
3. NAME OF DECEASED (Type or print) MABEL HELEN RAPOSO		4. DATE OF DEATH July 17, 1961	
5. SEX Female		6. COLOR OR RACE White	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH August 26, 1917	
9a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		9b. AGE (In years IF UNDER 1 YEAR last birthday) 43 yrs.	
10. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (County & State, or foreign country) Massachusetts	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Hillard Transue	
14. MOTHER'S MAIDEN NAME Anna Scallon		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No	
16. SOCIAL SECURITY NO. None		17. INFORMANT The Medical Record The Clinical Center, Bethesda 14, Maryland	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Septicemia DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) Acute Leukemia DUE TO (c) None		INTERVAL BETWEEN ONSET AND DEATH 7 days 4 month.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a):			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m., p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from July 19, 1961 to July 17, 1961 that (I) (we) last saw the deceased alive on July 17, 1961 and that death occurred at 3:00 PM from the causes and on the date stated above.			
22a. SIGNATURE Robert H. Levin		22b. DATE SIGNED 7/18/61	
22c. PHYSICIAN'S NAME (Type) Robert H. Levin, M.D.		22d. ADDRESS The Clinical Center, National Institutes of Health, Bethesda 14, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Bur-Transit 7/18/61		23b. DATE THEREOF	
23c. NAME OF CEMETERY OR CREMATORY Jacksonville Meory Gardens		23d. LOCATION (City, town or county) (State) Jacksonville, Florida	
24. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey		25a. REC'D BY REGISTRAR Jul 24 '61	
ADDRESS Bethesda, Maryland		25b. REGISTRAR'S SIGNATURE Arthur J. Thomas	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be returned by the hospital or attending physician to the funeral director. After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

2248

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

38241

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution. Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Dickerson		c. LENGTH OF STAY IN 1b 75 yrs	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Dickerson, Md	
3. NAME OF DECEASED (Type or print) First Howard Middle Calvin Last Roberson		4. DATE OF DEATH Month July Day 9 Year 1961	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 31-1885
9. AGE (In years last birthday) 75 yrs		10. IF UNDER 1 YEAR Months 75 Days 75 Hours 75 Min 75	11. IF UNDER 24 HRS Months 75 Days 75 Hours 75 Min 75
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Garage owner--Repairs etc.		10b. KIND OF BUSINESS OR INDUSTRY Maryland	
11. BIRTHPLACE (State or foreign country) U.S.		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Benjamin Roberson		14. MOTHER'S MAIDEN NAME Mary F. Purdy	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 218-32-2984	
17. INFORMANT Mrs Howard Roberson, Dickerson, Md		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Myelogenous Leukemia, Chronic. 154.1 DUE TO Polycythemia Vera Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) 10 years (c) 4 years		INTERVAL BETWEEN ONSET AND DEATH 4 years 10 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from April 11, 1949 to 9 July, 1961 , that (I) (we) last saw the deceased alive on 9 July 1961 , and that death occurred at 8 P.M. from the causes and on the date stated above.			
22a. SIGNATURE Gordon M. Smith		22b. DATE SIGNED 9 July 61	
22c. PHYSICIAN'S NAME (Type) Gordon M. Smith		22d. ADDRESS Barnesville, Md	
23a. BURIAL CREMATION, REMOVAL (Specify)		23b. DATE THEREOF	
Burial		7/12/61	
23c. NAME OF CEMETERY OR CREMATORY Monocacy		23d. LOCATION (City, town, or county) (State) Beallsville, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE Constance C. Hilton Barnesville, Md		25a. REC'D BY REGISTRAR DATE JUL 14 '61	
25b. REGISTRAR'S SIGNATURE Arthur S. Evans			



CERTIFICATE OF DEATH

g. Dist. No.

08242

8249

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockville,</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>10 Rockville</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>213 Ritchie Pkwy.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Teresa</u> Middle <u>Roccati</u> Last <u>Roccati</u>		4. DATE OF DEATH Month <u>July</u> Day <u>12</u> Year <u>1961</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>November 5, 1877</u>
9. AGE (In years last birthday) <u>83</u> yrs		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	IF UNDER 24 HRS Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <u>Italy</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>Battista Pellino</u>	
14. MOTHER'S MAIDEN NAME <u>Maria Varello</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>	
16. SOCIAL SECURITY NO. <u>578-05-1976B</u>		INFORMANT <u>Arnold J. Roccati</u> Address <u>Pitchie Pkwy. Rockville, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Rupture Aortic Aneurysm</u> <u>443X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hypertensive Cardiovascular Disease</u> DUE TO (c) <u>Generalized Arterio Sclerosis</u>			INTERVAL BETWEEN ONSET AND DEATH <u>5 MIN.</u> <u>20 Yr.</u> <u>30 Yr.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m. <u> </u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>1950</u> to <u>12 July</u> , 19 <u>61</u> , that I last saw the deceased alive on <u>21 June</u> , 19 <u>61</u> , and that death occurred at <u>5 AM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <u>7/12/61</u>			
ACTUAL SIGNATURE <u>John G. Ball</u> M.D.		PHYSICIAN'S NAME (Type) <u>John G. Ball</u> <u>7926 Old Georgetown Rd., Bethesda, Maryland</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>7/15/61</u>	22c. NAME OF CEMETERY OR CREMATORY <u>St. Mary's Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Rockville, Maryland</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Tyson Wheeler</u>		24a. REC'D BY REGISTRAR DATE <u>JUL 14 '61</u>	24b. REGISTRAR'S SIGNATURE <u>William S. Hume</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and complete filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural) c. LENGTH OF STAY IN b 9 days d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) U. S. Naval Hospital		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE MARYLAND b. COUNTY Virginia c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Falls Church d. STREET ADDRESS 506 Patrick Henry Drive	
3. NAME OF DECEASED (Type or print) Alyce Duke Roden		4. DATE OF DEATH July 11 1961	
5. SEX Female		6. COLOR OR RACE Caucasian	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 12-28-84	
9. AGE (In years last birthday) 76 yrs.		10. IF UNDER 1 YEAR Months 7 Days 11	
11. IF UNDER 24 HRS. Hours 1 Min. 15		12. CITIZEN OF WHAT COUNTRY? USA	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Mississippi	
11. BIRTHPLACE (County & State, or foreign country) Mississippi		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME William Riley Burke		14. MOTHER'S MAIDEN NAME Mary Mosley	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT (D) Mrs. Mary Meyer		Address Same as # 2 above	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: Acute Pulmonary edema 420.c DUE TO Infarction Myocardium Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO Arteriosclerotic Heart Disease		INTERVAL BETWEEN ONSET AND DEATH 1 hr 48 hrs 20 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) None		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) None		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) None	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) U. S. Naval Hospital, Bethesda, Md.		20f. (City or town) (County) (State) St. Petersburg, Fla	
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from July 2, 1961 , to July 11, 1961 that <input checked="" type="checkbox"/> (we) last saw the deceased alive on July 11, 1961 , and that death occurred at 1:12 PM from the causes and on the date stated above.		22a. SIGNATURE Vernon N. Houk M.D. 22b. DATE SIGNED 7-11-61	
22c. PHYSICIAN'S NAME (Type) VERNON N. HOUK, LCDR MC USN		22d. ADDRESS U. S. Naval Hospital, Bethesda, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial -- Shippment 7-12-61		23b. DATE THEREOF 7-12-61	
23c. NAME OF CEMETERY OR CREMATORY Royal Palm		23d. LOCATION (City, town or county) (State) St. Petersburg, Fla	
24. FUNERAL DIRECTOR'S SIGNATURE Tyson Wheeler ADDRESS Tyson Wheeler, Rockville, Md.		25a. REC'D BY REGISTRAR JUL 13 '61	
25b. REGISTRAR'S SIGNATURE Arthur S. Fries			

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If an autopsy is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

Item 10 File 294 9-7-61 MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
2251 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 08244

1. PLACE OF DEATH
a. COUNTY Montgomery MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Takoma Park
c. LENGTH OF STAY IN 1b 80A
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Washington Sanitation

2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)
a. STATE Maryland b. COUNTY Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 4280 Bel Air Road
d. STREET ADDRESS 16012 Johnson Ave
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print)
First Middle Last
Rebekah Sarah Schenker

4. DATE OF DEATH
Month Day Year
7 28 1961

5. SEX Female 6. COLOR OR RACE White 7. MARRIED ☐ NEVER MARRIED ☐ 8. DATE OF BIRTH July 1, 61
WIDOWED ☐ DIVORCED ☐ 9. AGE (In years last birth day) 27 yrs. IF UNDER 1 YEAR: Months Days Hours M n. IF UNDER 24 HRS: Months Days Hours M n.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) 10b. KIND OF BUSINESS OR INDUSTRY 11. BIRTH PLACE (State or foreign country) D. C. 12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME IRVING I. SCHENKER 14. MOTHER'S MAIDEN NAME GILDA KRUGER

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) 16. SOCIAL SECURITY NO. 17. INFORMANT Address I. I. SCHENKER - 6012 JOHNSON AV.

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Pulmonary atelectasis and pulmonary alveolar insufficiency
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I: a) 19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH. 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 20d. INJURY OCCURRED While at work ☐ Not While at work ☐ 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☒ Inspection ☐ Inquiry ☐ and in my opinion death resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐
CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☐ DEPUTY MEDICAL EXAMINER ☒ DATE SIGNED 7-29-61
ACTUAL SIGNATURE Frank J. Broschert M.D. EXAMINER'S NAME (Type) FRANK J. Broschert Address (Street, city, town, or county)
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL 22b. DATE THEREOF JULY 30, 1961 22c. NAME OF CEMETERY OR CREMATORY ADAS ISRAEL CEMETERY 22d. LOCATION (City, town, or country) (State) WASHINGTON DC.

23. FUNERAL DIRECTOR Bernard Shapshaydons ADDRESS 3501-14 ST. NW. 24a. REGISTRY REGISTRAR Sub 1 61 DATE 24b. REGISTRAR'S SIGNATURE Arthur S. Kraus

9VVVVV. XV



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 may be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

8252

68245

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>TRIKOMA PARK</u> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>WASH. SANT.</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>1</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u> d. STREET ADDRESS <u>8902 Glenville Rd.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>RUTH</u> First <u>EVERET</u> Middle <u>SCHIMMACK</u> Last 4. DATE OF DEATH <u>July 20</u> Month <u>1961</u> Day Year		5. SEX <u>Female</u> 6. COLOR OR RACE <u>White</u> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH <u>5-1-95</u> 9. AGE (in years last birthday) <u>66</u> yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u> 11. BIRTHPLACE (County & State, or foreign country) <u>Pa</u> 12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>Harry Hull</u> 14. MOTHER'S MAIDEN NAME <u>Minnie Mackling</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year of service) <u>—</u> 16. SOCIAL SECURITY NO. <u>—</u> 17. INFORMANT <u>August F Schimmack</u> Address <u>8902 Glenville Rd.</u>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1</u> DUE TO <u>Coronary thrombosis</u> Conditions, if any, which gave rise to immediate cause (b) <u>Arteriosclerosis</u> (a), stating the underlying cause last. (c) <u>—</u> DUE TO <u>—</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a). 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>April</u> 19 <u>59</u> to <u>July 20</u> 19 <u>61</u> ; that (I) (we) last saw the deceased alive on <u>July 21</u> 19 <u>61</u> , and that death occurred at <u>6 P.</u> M. from the causes and on the date stated above.			
22a. SIGNATURE <u>[Signature]</u> M.D. 22b. DATE SIGNED <u>7/21/61</u>		ATTENDING PHYS <u>[Signature]</u> MED. DIRECTOR <u>ROBIN, M.D.</u> 22d. ADDRESS <u>317 UNIV. BLVD. EAST SILVER SPRING, MD.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> 23b. DATE THEREOF <u>7/24/61</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Arlington Natl Cem.</u> 23d. LOCATION (Town or county) (State) <u>Arlington Va.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Deal Funeral Home</u> ADDRESS <u>4812 Heavens</u>		25a. REC'D BY REGISTRAR <u>—</u> DATE <u>JUL 25 '61</u> 25b. REGISTRAR'S SIGNATURE <u>Arthur S. Hines</u>	



TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
ISM 9/59

CERTIFICATE OF DEATH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glen-Mar Park		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glen-Mar Park	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 5915 Namakagan Road		d. STREET ADDRESS 5915 Namakagan Road	
3. NAME OF DECEASED (Type or print) First Luther Middle Eberts Last Schreiner		4. DATE OF DEATH Month July Day 23 Year 1961	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5/9/1883
9. AGE (In years last birthday) 78 yrs		10. FUND 1 YEAR: Months 7 Days 23 Hours 1 Min 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Stock Broker- Jones Creiger & Co.		10b. KIND OF BUSINESS OR INDUSTRY Washington, D. C.	
11. BIRTHPLACE (State or foreign country) U. S. A.		12. CITIZEN OF WHAT COUNTRY U. S. A.	
13. FATHER'S NAME Edmund E. Schreiner		14. MOTHER'S MAIDEN NAME Caroline C. Davis	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 577-22-1710	
17. INFORMANT Helen H. Schreiner -same as 2-d		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]			
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Acute myocardial infarction			
DUE TO Generalized arteriosclerosis with coronary sclerosis			
(c) Chronic heart failure			
PART I. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 6 hours			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Jan 2 59 to July 23 61 that (I) (we) last saw the deceased alive on July 23 1961 and that death occurred on July 23 1961 from the causes and on the date stated above			
22a. SIGNATURE C. P. RYLAND		22b. DATE SIGNED 7-23-61	
22c. PHYSICIAN'S NAME (Type) C. P. RYLAND		22d. ADDRESS 4400-49 4th NW Washington DC	
23a. BURIAL, CREMATION REMOVAL (Specify) cremation		23b. DATE THEREOF 7/24/61	
23c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln Crematory		23d. LOCATION (City, town, or county) (State) Prince Georges Co. Md.	
24. FUNERAL DIRECTOR'S SIGNATURE The S. H. Hines Co. Washington, D. C.		25a. REC'D BY REGISTRAR JUL 25 '61	
25b. REGISTRAR'S SIGNATURE Arthur L. Hines			

08246



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be used by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

8254

CERTIFICATE OF DEATH

Reg. Dist. No. 08247

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) b. STATE <u>md.</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Olney</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington Grove</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OF INSTITUTION <u>Brooke Grove Foundation Inc.</u>		d. STREET ADDRESS <u>409 Brown St.</u>	
3. NAME OF DECEASED (Type or print) <u>George Lewis Seaton</u>		4. DATE OF DEATH <u>July 28, 1961</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct 24, 1880</u>
9. AGE (In years last birthday) <u>80</u> yrs		10. UNDER 1 YEAR <u>7</u> Months <u>4</u> Days <u></u> Hours <u></u> Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u></u>	
11. BIRTHPLACE (State or foreign country) <u>Nebraska</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>George L. Seaton</u>		14. MOTHER'S MAIDEN NAME <u>Sarah Hatcher</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u></u>		16. SOCIAL SECURITY NO. <u></u>	
17. INFORMANT <u>Alford Brooks</u>		18. ADDRESS <u>409 Brown St. Wash. Grove</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral thrombosis (probable)</u> <u>1 wk</u>			
DUE TO (b) <u>Cerebral & generalized arteriosclerosis</u>			
DUE TO (c) <u></u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>that Pulmonary Emphysema</u>			
INTERVAL BETWEEN ONSET AND DEATH <u></u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)			
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) <u></u>			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>			
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u></u>			
20f. (City or town) (County) (State) <u></u>			
21. I certify that I attended the deceased from <u>6/4</u> , 19 <u>61</u> , to <u>7/28</u> , 19 <u>61</u> , that I last saw the deceased alive on <u>7/24</u> , 19 <u>61</u> , and that death occurred at <u>4:20</u> PM, from the causes and on the date stated above.			
ADDRESS (Street, city or town, state) <u></u> DATE SIGNED <u>7/25/61</u>			
ACTUAL SIGNATURE <u>John P. Martin MD</u> <u>Sandy Spengler</u>			
PHYSICIAN'S NAME (Type) <u>JOHN P. MARTIN MD</u> <u>SANDY SPRING</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Buried</u>			
22b. DATE THEREOF <u>7/31/61</u>			
22c. NAME OF CEMETERY OR CREMATORY <u>Forest Oak</u>			
22d. LOCATION (City or town, or county) (State) <u>Gaithersburg Md</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>Edo Gaithersburg</u> ADDRESS <u></u>			
24a. REC'D BY REGISTRAR <u></u> DATE <u>AUG 3 '61</u>			
24b. REGISTRAR'S SIGNATURE <u></u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
8255
00248

1. PLACE OF DEATH a. COUNTY <u>DETHESDA</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>DETHESDA</u> c. LENGTH OF STAY IN 1b <u>1 yr.</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>1</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>DETHESDA</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>DETHESDA</u> d. STREET ADDRESS <u>1</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Richard</u> Middle <u>Sewell</u> Last <u>Seawell</u>		4. DATE OF DEATH Month <u>11</u> Day <u>17</u> Year <u>1961</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> 8. DATE OF BIRTH <u>July 1, 1924</u>	9. AGE (In years last birthday) <u>37</u> yrs. IF UNDER 1 YEAR: Months <u>0</u> Days <u>0</u> IF UNDER 24 HRS.: Hours <u>0</u> Mins. <u>0</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>NO</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>MD</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Richard Sewell</u>		14. MOTHER'S MAIDEN NAME <u>Bessie</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>1-44-111111</u>	
17. INFORMANT <u>Richard Sewell</u>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>confluent Bronchopneumonia</u> 260X DUE TO <u>Chemia</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO <u>Diabetic nephropathy</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>None</u>	
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II. of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m. <u>19</u>	
20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) <u>Quince Orchard, Md.</u>		20g. (County) <u>Quince Orchard, Md.</u>	
20h. (State) <u>Quince Orchard, Md.</u>		21. I certify that (I) (this hospital) attended the deceased from....., 19....., to....., 19....., that (I) (we) last saw the deceased alive on.....19....., and that death occurred at.....M, from the causes and on the date stated above.	
22a. SIGNATURE <u>Richard Sewell</u> M.D.		22b. DATE SIGNED <u>9/20/61</u>	
22c. PHYSICIAN'S NAME (Type) <u>Richard Sewell</u>		22d. ADDRESS <u>3100 Monticello Dr. Rockville, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>7/12/61</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Pleasant View.</u>		23d. LOCATION (City, town or county) <u>Quince Orchard, Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Arthur L. Kneese</u>		25a. REC'D BY REGISTRAR <u>Arthur L. Kneese</u>	
25b. REGISTRAR'S SIGNATURE <u>Arthur L. Kneese</u>		25c. DATE <u>JUL 17 '61</u>	

TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
8256
CERTIFICATE OF DEATH

08249

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution - Residence before admission) a. STATE Maryland b. COUNTY ---	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Gaithersburg	c. LENGTH OF STAY IN 1b 1 year	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Asbury Methodist Home for the Aged, Inc.		d. STREET ADDRESS 3405 Garrison Blvd.	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Clarence Middle M. Last Shepherd		4. DATE OF DEATH Month July Day 31 Year 1961	
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan. 13, 1889
9. AGE (In years last birthday) 72 yrs		IF UNDER 1 YEAR Months --- Days ---	IF UNDER 24 HRS Hours --- Min. ---
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) School Teacher		10b. KIND OF BUSINESS OR INDUSTRY Retired	11. BIRTHPLACE (State or foreign country) Pennsylvania
12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Francis J. Shepherd		14. MOTHER'S MAIDEN NAME Mary Moore	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) unknown (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 213-14-3940	17. INFORMANT Address Records of Asbury Home, Gaithersburg, Md.
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Peripheral Circulatory Collapse DUE TO (b) Complete Heart Block Conditions if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) Arteriosclerotic Heart Disease			INTERVAL BETWEEN ONSET AND DEATH 6 hours 5 years 5 years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION, GIVEN IN PART I (a) Hypoglycemic Shock Due To Insulin			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part I. of item 18.)	
20c. TIME OF INJURY Month, Day Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from December 1960 to July 31, 1961 , that (I) (we) last saw the deceased alive on July 31, 1961 , and that death occurred at 4:40 A. from the causes and on the date stated above.			
22a. SIGNATURE James W. Egan		22b. ADDRESS 7720 Wisconsin Ave., Bethesda 14, Md.	22c. PHYSICIAN'S NAME (Type) James W. Egan
23a. BURIAL, CREMATION, OR REMOVAL (Specify) Burial		23b. DATE THEREOF 8-2-61	23c. NAME OF CEMETERY OR CREMATORY Woodlawn
23d. LOCATION (City, town, or county) Woodlawn, Md.			
24. FUNERAL DIRECTOR'S SIGNATURE Wm. J. Pickens & Sons		25a. REC'D BY REGISTRAR DATE AUG 3 '61	
25b. REGISTRAR'S SIGNATURE Charles E. Turner			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

Item 18 Filed 8-3-61
292
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
8257
CERTIFICATE OF DEATH
08250

1. PLACE OF DEATH
a. COUNTY Montgomery MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Bethesda
c. LENGTH OF STAY IN IS 12 days
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Suburban

2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)
a. STATE Maryland
b. COUNTY Montgomery
c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Takoma Park
d. STREET ADDRESS 7620 Maple Ave.

3. NAME OF DECEASED (Type or print) Anna J. Simonton
4. DATE OF DEATH July 16 1961

5. SEX Female 6. COLOR OR RACE White 7. MARRIED ☒ NEVER MARRIED ☐ 8. DATE OF BIRTH 5/28/02
9. AGE (in years last birthday) 59 yrs. IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Homemaker 10b. KIND OF BUSINESS OR INDUSTRY Conn. 11. BIRTHPLACE (County & State, or foreign country) U.S.A. 12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME William Davern 14. MOTHER'S MAIDEN NAME Mary ~~Yoga~~ BYRNES

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No 16. SOCIAL SECURITY NO. 577-01-0305 17. INFORMANT Husband Same as above

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) PNEUMONITIS - POST-OP.
545X DUE TO
Condition, y, w, ich (b) GASTRIC BLEEDING - GENERALIZED MUCOSA
gave rise to immediate cause (e), stating the underlying cause last. DUE TO (c) Operation: Gastrectomy

INTERVAL BETWEEN ONSET AND DEATH 17 DAYS

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)
19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER). 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 20d. INJURY OCCURRED While at work ☐ Not While at work ☐ 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 7 JULY, 1961, to 16 JUL, 1961, that (I) (we) last saw the deceased alive on 16 JUL, 1961, and that death occurred at 6:50 A.M. from the causes and on the date stated above.

22a. SIGNATURE L. Marshall Cuvillier, Jr. 22b. DATE SIGNED 7-16-61
22c. PHYSICIAN'S NAME (Type) L. Marshall Cuvillier Jr. 22d. ADDRESS 1407 Woodside 1 Ky, Silver Spring

23a. BURIAL, CREMATION, REMOVAL (Specify) Burial 23b. DATE THEREOF July 19, 1961 23c. NAME OF CEMETERY OR CREMATORY Gate Of Heaven Cemetery 23d. LOCATION (City, town or county) (State) Montgomery, Maryland

24. FUNERAL DIRECTOR'S SIGNATURE Warner E. Pumphrey, Inc. 25a. REC'D BY REGISTRAR August 1 9 '61 25b. REGISTRAR'S SIGNATURE Arthur S. Kraus

1
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

(M)

5

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

8258

08251

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>DC</u> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>New Great Falls</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington</u> + 7X	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Wide Water - C & O Canal</u>		d. STREET ADDRESS <u>2518 17th St, N.W.</u>	
3. NAME OF DECEASED (Type or print) <u>Johnnie Robert Simpson</u>		4. DATE OF DEATH <u>July 29 1961</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>7-6-1936</u>
9. AGE (In years last birthday) <u>25</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Truck driver</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Canary dry</u>	
11. BIRTHPLACE (State or foreign country) <u>D.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Johnnie Carter Simpson</u>		14. MOTHER'S MAIDEN NAME <u>Minnie Robertson</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service)		16. SOCIAL SECURITY NO. <u>Unknown</u>	
17. INFORMANT <u>Francis Simpson - 4345 4th St D.C.</u>		Address <u>4345 4th St D.C.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Asphyxia</u> <u>drowning</u> Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. <u>729.8</u> DUE TO (b) <u>Asphyxia</u> DUE TO (c) <u>drowning</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Drowned while swimming in C & O Canal</u>	
20c. TIME OF INJURY Month, Day, Year Hour <u>7:15</u> p.m. <u>7-29</u> 19 <u>61</u>		20d. INJURY OCCURRED While <input checked="" type="checkbox"/> Not While <input type="checkbox"/> et work <input type="checkbox"/> et work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>C & O Canal</u>	
20f. (City or town) <u>Great Falls</u> (County) <u>Montg</u> (State) <u>Md</u>			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Frank J. Brosch</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>FRANK J. BROSCHEAT</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF	
22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or country) (State)	
Burial-transit 8-1-61 Mill Creek Baptist Church Chatham, Virginia			
23. FUNERAL DIRECTOR <u>ROBERT A. PUMPHREY</u>		24. REC'D BY REGISTRAR <u>Arthur L. Kneass</u>	
ADDRESS <u>Bethesda, Md.</u>		DATE <u>AUG 2 '61</u>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

2250		Item 4		99253	
1. PLACE OF DEATH a. COUNTY <u>Montgomery</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>			
c. LENGTH OF STAY in lb <u>35 min</u>		d. STREET ADDRESS <u>8500 New Hampshire Ave</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Washington San & Hosp</u>		e. DATE OF DEATH <u>July 10 1961</u>		f. IF UNDER 1 YEAR: Months <u>4</u> Days <u>11</u> Hours <u>17</u> M'n. <u>44</u>	
3. NAME OF DECEASED (Type or print) <u>David NMM Spatzer</u>		8. DATE OF BIRTH <u>4-11-17</u>		9. AGE (in years last birthday) <u>44</u> yrs.	
5. SEX <u>M</u>		6. COLOR OR RACE <u>White</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Court Reporter</u>	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		11. BIRTHPLACE (County & State, or foreign country) <u>New York</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME <u>SAM SPATZER</u>		14. MOTHER'S MAIDEN NAME <u>LENA EHRlich</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>LINK</u>		16. SOCIAL SECURITY NO <u>082-10-4123</u>		17. INFORMANT <u>Mrs. Madrian Sturgeon - 8500-N. Hampshire Ave. S.S. Md.</u>	
18. CAUSE OF DEATH (Enter only one cause per type for (a), (b), and (c))		INTERVAL BETWEEN ONSET AND DEATH <u>4 weeks</u>			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>416X</u> DUE TO <u>Pulmonary edema</u>		DUE TO <u>Congestive heart disease-failure</u>		2 years	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO <u>Rheumatic heart disease</u>				35 years	
PART I. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a):					
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a.m. _____ p.m. _____ Month, Day, Year _____ 19 _____		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) _____ (County) _____ (State) _____					
21. I certify that (I) (this hospital) attended the deceased from _____, 1953, to _____, 1961, that (I) (we) last saw the deceased alive on _____, 1961, and that death occurred at _____ M, from the causes and on the date stated above.					
22a. SIGNATURE <u>Arthur S. Bresler</u>		22b. DATE SIGNED _____			
22c. PHYSICIAN'S NAME (Type) <u>ARTHUR S. BRESLER</u>		22d. ADDRESS <u>10881 COLESVILLE RD Silver Spring</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>7-13-61</u>		23c. NAME OF CEMETERY OR CREMATORY <u>KING DAVID MEMORIAL GARDEN FALLS CHURCH - VA.</u>	
23d. LOCATION (City, town or county) _____ (State) _____					
24. FUNERAL DIRECTOR'S SIGNATURE <u>B. DANZANSKY & SONS - 2501-14th St. N.W.</u>		25a. REC'D BY REGISTRAR <u>JUL 17 '61</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Bresler</u>	

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15M 9/60

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 4 may be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

8261

08254

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u> c. LENGTH OF STAY IN 1b <u>17 days</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Washington San. + Hospital</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince George</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Berwyn Heights</u> d. STREET ADDRESS <u>8607 - 57th ave</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Lillian Estelle Stanner</u>		4. DATE OF DEATH Month <u>7</u> Day <u>30</u> Year <u>1961</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>9-30-01</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own home</u>	11. BIRTHPLACE (County & State, or foreign country) <u>D. C.</u>
13. FATHER'S NAME <u>Russell</u>		14. MOTHER'S MAIDEN NAME <u>U. S. A.</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <u>None</u>		17. INFORMANT <u>Husband</u> Address <u>Same as above</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Left Internal Corotid Thrombosis</u> (b) <u>H. A. S. H. D.</u> (c) <u>Diabetes Mellitus - Coronary sclerosis</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Injury of left hemisphere of Brain</u>			
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year <u>19</u> Hour a.m. <u>6:55</u> p.m. <u>57</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) <u>1100 SPRING STREET</u> <u>SILVER SPRING, MD.</u>
21. I certify that (I) (this hospital) attended the deceased from <u>6-5-57</u> 19 <u>57</u> to <u>7-30</u> 1961 , that (I) (we) last saw the deceased alive on.. <u>7-29-1961</u> and that death occurred at.. <u>9 A.M.</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>Jason Geiger</u>		22b. DATE SIGNED <u>7-30-61</u>	
22c. PHYSICIAN'S NAME (Type) <u>Jason Geiger MD</u>		22d. ADDRESS <u>1100 SPRING STREET</u> <u>SILVER SPRING, MD.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>Aug 2, 1961</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Ft Lincoln Cemetery</u>	23d. LOCATION (City, town or county) <u>Colmar Manor, Md.</u> (State)
24. FUNERAL DIRECTOR'S SIGNATURE <u>F. Gasch's Sons</u>		25a. REC'D BY REGISTRAR <u>AUG 3 '61</u>	
25b. REGISTRAR'S SIGNATURE <u>Anthony S. Kraus</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed 24 hours after death. Pages 3 & 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

2262

82255

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>Maryland</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park, Md</u> c. LENGTH OF STAY in 1b <u>42 days</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Washington Hospital</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Springfield</u> d. STREET ADDRESS <u>8155 St. ...</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>PEARL H. STAUBLY</u>		4. DATE OF DEATH <u>7/16</u> 19 <u>61</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12-23-14</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (County and State, or foreign country) <u>South Dakota</u>
13. FATHER'S NAME <u>F. M. Powell</u>		14. MOTHER'S MAIDEN NAME <u>Florence Mc ...</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		17. INFORMANT <u>Dr. ...</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CEREBRAL HEMORRHAGE</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>HYPERTENSIVE CARDIOVASC. DISEASE</u> (c) <u>CEREBRAL ARTERIOSCLEROSIS</u>		INTERVAL BETWEEN ONSET AND DEATH <u>6 weeks</u> <u>2 YRS</u> <u>2 YRS</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I. a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>6/4</u> 19 <u>61</u> , to <u>7/16</u> 19 <u>61</u> , that (I) (we) last saw the deceased alive on <u>7/15</u> 19 <u>61</u> , and that death occurred at <u>10 A</u> M, from the causes and on the date stated above.			
22c. PHYSICIAN'S NAME (Type) <u>DAVID GOLDENBERG</u>		22b. DATE SIGNED <u>7/16/61</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>7/18/1961</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Green Hill Cemetery</u>	23d. LOCATION (City, town or county) (State) <u>Martinsburg, West Virginia</u>
24. FUNERAL DIRECTOR'S SIGNATURE <u>S H Hines Co.</u>		25a. REC'D BY REGISTRAR <u>2901 14th Ave</u>	25b. REGISTRAR'S SIGNATURE <u>Jul 18 '61</u>

12
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

(M)

(I)

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

68256

1. PLACE OF DEATH
a. COUNTY Montgomery MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Takoma Park
c. LENGTH OF STAY IN 1b
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) West Smithing

2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission)
a. STATE Maryland b. COUNTY Prince George's
c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Hyattsville
d. STREET ADDRESS 7905 14th Ave

3. NAME OF DECEASED (Type or print)
First Middle Last
Christian Henry Stoeber

4. DATE OF DEATH
Month Day Year
7 1 1961

5. SEX male 6. COLOR OR RACE white 7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐ 8. DATE OF BIRTH 11-22-1887 9. AGE (In years last birthday) 73 yrs. 10. IF UNDER 1 YEAR Months Days 11. IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ret'd 10b. KIND OF BUSINESS OR INDUSTRY Wholesale, wine 11. BIRTHPLACE (State or foreign country) U.S.C. 12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME Henry W. 14. MOTHER'S MAIDEN NAME Mrs Catherine H. Stoeber

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) no 16. SOCIAL SECURITY NO. Ruth Holbrook Hyattsville Md 17. INFORMANT Ruth Holbrook Hyattsville Md

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Coronary occlusion
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause and (c)
DUE TO
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)
History of previous heart disease

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐ Inspection ☒ Inquiry ☒ and in my opinion death resulted from Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☐ DEPUTY MEDICAL EXAMINER ☒

ACTUAL SIGNATURE Frank J. Broschart EXAMINER'S NAME (Type) FRANK J. BROSCART DATE SIGNED 7-1-61

Address (Street, city, town, or county)

22a. BURIAL, CREMATION, REMOVAL (Specify) Burial 22b. DATE THEREOF 7/5/61 22c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln 22d. LOCATION (City, town, or country, State) Colmar Manor, Md.

23. FUNERAL DIRECTOR F. Gasch's Sons ADDRESS Hyattsville, Md. 24a. REC'D BY REGISTRAR JUL 5 '61 DATE 24b. REGISTRAR'S SIGNATURE Arthur L. Howard

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
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15M 9/60

1
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
8264
CERTIFICATE OF DEATH
02257

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Bethesda (Rural) c. LENGTH OF STAY IN b 32 days d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) U. S. Naval Hospital		2. USUAL RESIDENCE (Where deceased lived, if not full on; Residence before admission) a. STATE Maryland b. COUNTY A c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Crownsville d. STREET ADDRESS ---	
3. NAME OF DECEASED (Type or print) Paul First Middle Last SULLIVAN		4. DATE OF DEATH July 7 1961 Month Day Year	
5. SEX Male		6. COLOR OR RACE Caucasian	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 12-31-95 Month Day Year	
9. AGE (In years last birthday) 65 yrs.		10. UNDER 1 YEAR <input type="checkbox"/> IF UNDER 24 HRS. <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Officer		10b. KIND OF BUSINESS OR INDUSTRY U. S. Marine Corps	
11. BIRTHPLACE (County & State, or foreign country) Texas		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME William SULLIVAN		14. MOTHER'S MAIDEN NAME Mary BURNS	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes		16. SOCIAL SECURITY NO. (W) Esther Sullivan, same as #2 above	
17. INFORMANT (W) Esther Sullivan, same as #2 above		Address ---	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I: DEATH WAS CAUSED BY IMMEDIATE CAUSE (a). Post-operative Complication with Cardiac De compensation DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic Heart disease DUE TO (c) Benign Prostatic Hypertrophy PART II: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I, a) 2 yrs			
19. INTERVAL BETWEEN ONSET AND DEATH 12 hrs			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (this hospital) attended the deceased from June 5 1961 to July 7 1961 , that (s) (we) last saw the deceased alive on July 7 1961 , and that death occurred at 5:30PM , from the causes and on the date stated above.			
22a. SIGNATURE H. S. IRONS, LT, MC, USN		22b. DATE SIGNED 7-8-61	
22c. PHYSICIAN'S NAME (Type) H. S. IRONS, LT, MC, USN		22d. ADDRESS U. S. Naval Hospital, Bethesda, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 7-12-61	
23c. NAME OF CEMETERY OR CREMATORY Arlington National		23d. LOCATION (City, town or county) (State) Arlington Virginia	
25a. REC'D BY REGISTRAR H. S. Hines Funeral Home, 2901 14th St. NW, Wash DC		25b. REGISTRAR'S SIGNATURE Arthur S. Hines	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 may be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 may be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 may be retained by the hospital or attending physician.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

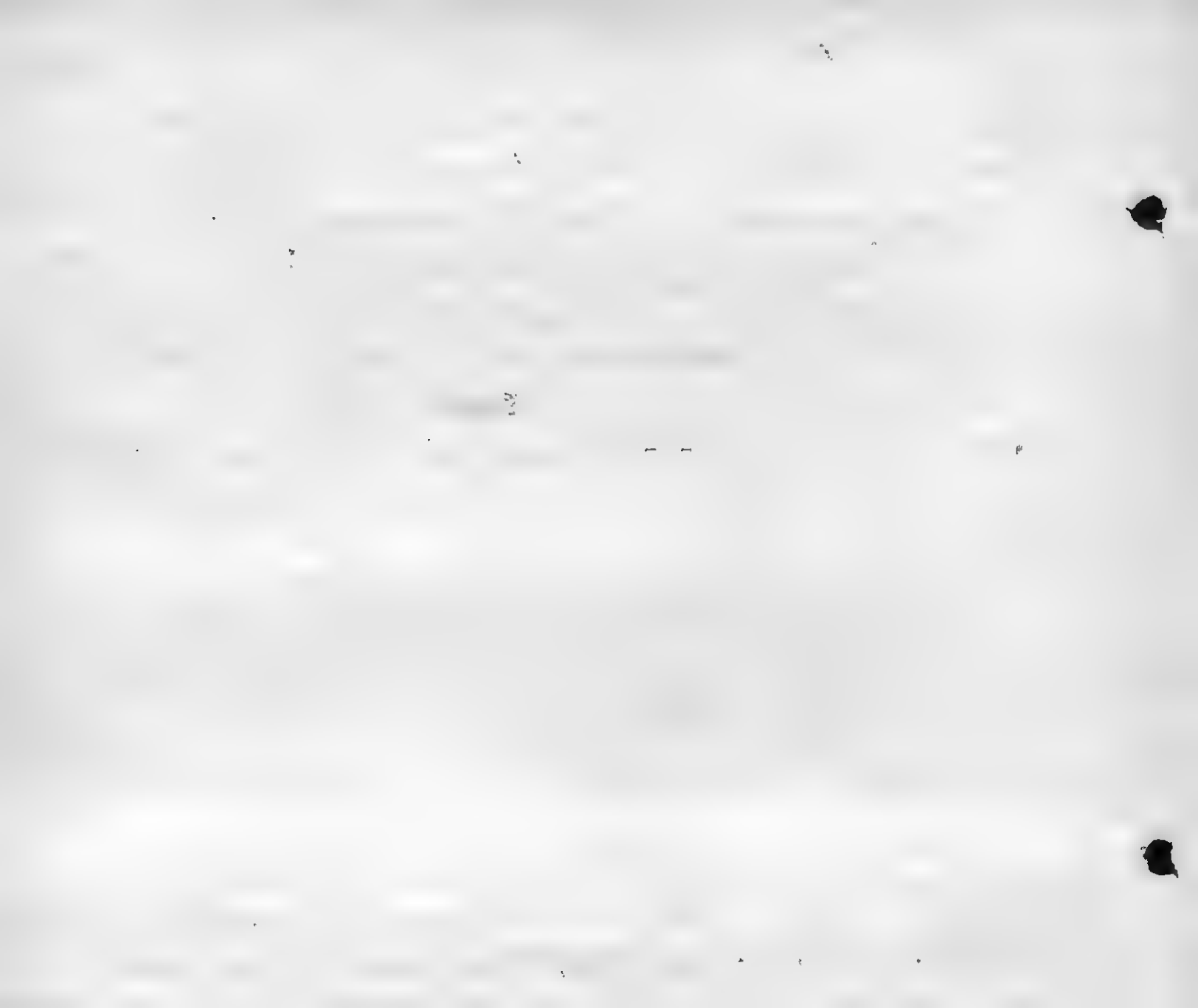
8265

08250

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u> c. LENGTH OF STAY in lb <u>8 hrs.</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Washington Sanitarium + Hospital</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>415 Univ. Silver Spring</u> d. STREET ADDRESS <u>415 University Blvd., W.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) <u>Laurence David Sweeney</u>		4. DATE OF DEATH <u>July 23 1961</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH <u>June 22, 1919</u>	9. AGE (In years, last birthday) <u>42 yrs.</u>	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Conductor</u>
11. BIRTHPLACE (County & State or foreign country) <u>Wash. Terminal Co. Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>James E. Sweeney</u>
14. MOTHER'S MAIDEN NAME <u>Estelle Hall</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> <u>W.W. 2</u> <u>578-12-3860</u>		16. SOCIAL SECURITY NO. <u>578-12-3860</u>
17. INFORMANT <u>Washington Sanitarium and Hospital</u>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>052X</u> DUE TO <u>Anaphylactic shock due to erysipelas</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, notify medical examiner) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <input type="checkbox"/>		20c. TIME OF INJURY Month, Day, Year Hour <u>19</u> a.m. <input type="checkbox"/> p.m. <input type="checkbox"/>
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <input type="checkbox"/>		20f. (City or town) (County) (State) <input type="checkbox"/>
21. I certify that (I) (this hospital) attended the deceased from July 21, 1961, to July 23, 1961, that (I) last saw the deceased alive on July 23, 1961, and that death occurred at 20 AM, from the causes and on the date stated above.				
22a. SIGNATURE <u>Raymond Bradshaw</u>		22b. DATE SIGNED <u>7/23/61</u>		22c. PHYSICIAN'S NAME (Type) <u>Raymond Bradshaw</u>
22d. ADDRESS <u>345 University Blvd W. Silver Spring, Md.</u>		22e. REC'D BY REGISTRAR <u>Charles E. Hanna</u>		22f. REGISTRAR'S SIGNATURE <u>Charles E. Hanna</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>7/26/61</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Arlington National Cemetery Arlington, Virginia</u>
23d. LOCATION (City, town or county) <u>Arlington, Virginia</u>		23e. NAME OF CEMETERY OR CREMATORY <u>8434 Georgia Avenue Silver Spring, Maryland</u>		23f. LOCATION (City, town or county) <u>Silver Spring, Maryland</u>

Records

INTERVAL BETWEEN ONSET AND DEATH



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

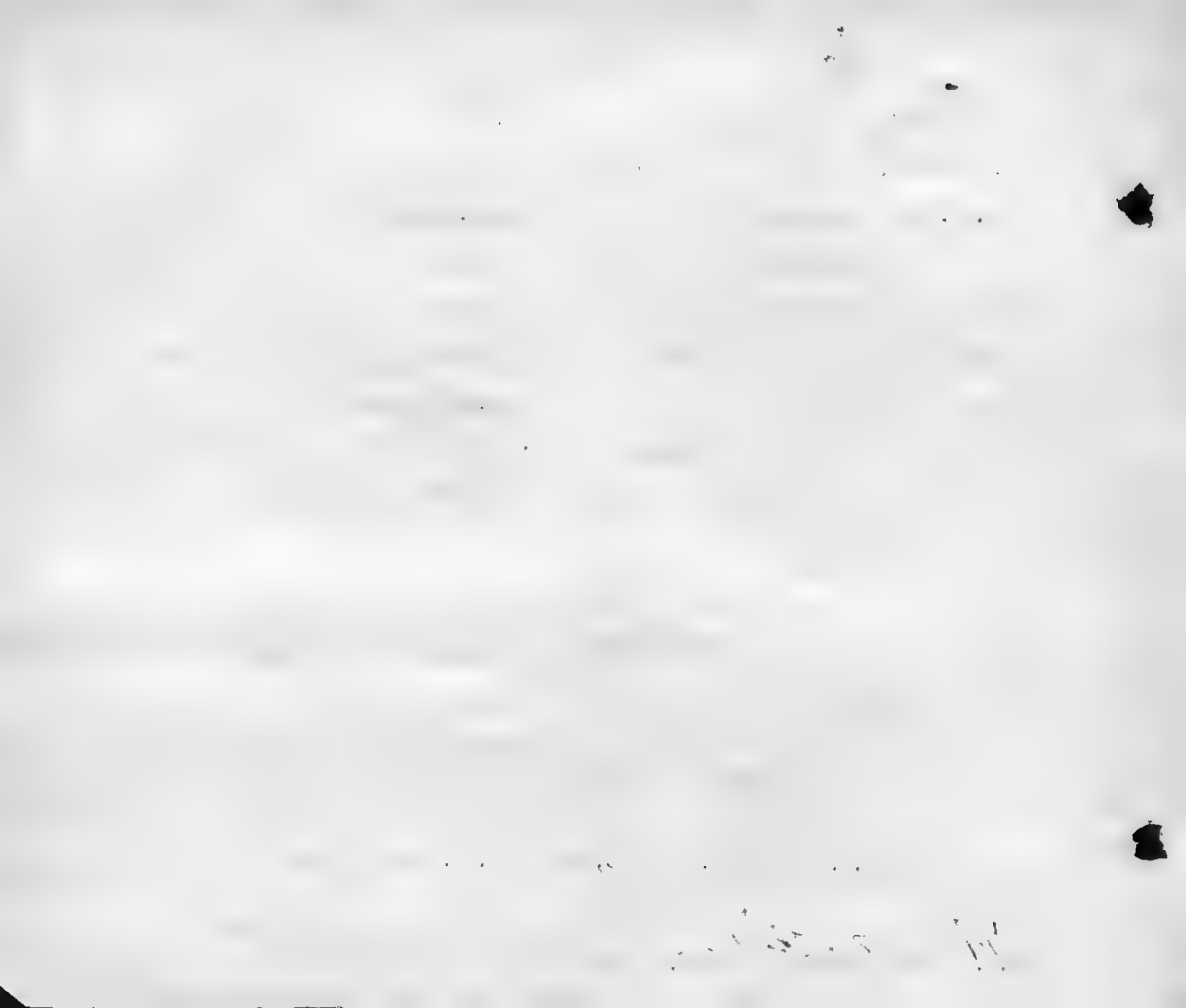
1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>	
c. LENGTH OF STAY IN 1b <u>35 days</u>		d. STREET ADDRESS <u>8414 Flower Ave</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Washington DANE Hosp</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Imogene Alice Swift</u>		4. DATE OF DEATH <u>7/5</u> 19 <u>61</u>	
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>1-14-83</u>	
9. AGE (In years last birthday) <u>78</u> yrs.		10. IF UNDER 1 YEAR Months <u>7</u> Days <u>5</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>D.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>American</u>	
13. FATHER'S NAME <u>James C Clark</u>		14. MOTHER'S MAIDEN NAME <u>Mary Coon</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>Hosp. record.</u>	
17. INFORMANT <u>Hosp. record.</u>		Address <u>Hosp. record.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARCINOMATOSIS & UREMIA</u>			
DUE TO (b) <u>CARCINOMA OF BLADDER</u>			
DUE TO (c) <u>CONGESTIVE HEART FAILURE</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19			
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>DECEMBER 1960</u> to <u>5 JULY</u> 19 <u>61</u> , that (I) (we) last saw the deceased alive on <u>5 JULY</u> 19 <u>61</u> , and that death occurred at <u>10 PM</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>Morrill C. Quinnam Jr</u> M.D.			
22b. DATE SIGNED			
22c. PHYSICIAN'S NAME (Type) <u>MORRILL C QUINNAM JR</u>			
22d. ADDRESS <u>7600 CARROLL AVE. TAKOMA PARK, MD</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>			
23b. DATE THEREOF <u>7-8-61</u>			
23c. NAME OF CEMETERY OR CREMATORY <u>Glenwood Cemetery</u>			
23d. LOCATION (City, town or county) (State) <u>Washington D.C.</u>			
24. FUNERAL DIRECTOR'S SIGNATURE <u>Frank Seiers Sons Co</u>			
ADDRESS <u>3605-14 St NW Wash. D.C.</u>			
25a. REC'D BY REGISTRAR <u>DATE JUL 7 '61</u>			
25b. REGISTRAR'S SIGNATURE <u>Arthur L. Harris</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH
08260

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Bethesda (Rural) c. LENGTH OF STAY IN 1b 17 days d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) U. S. Naval Hospital		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Virginia b. COUNTY Quantico c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Quantico d. STREET ADDRESS Qts. 2066A, MCS e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Emily Jackson First Middle 4. DATE OF DEATH Last TATES July 14 19 61		5. SEX Female 6. COLOR OR RACE Negro 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH 12-6-99 9. AGE (In years, If UNDER 1 YEAR; If UNDER 24 HRS. last birthday) Months Days Hours M'n. 61 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housekeeper 10b. KIND OF BUSINESS OR INDUSTRY Home 11. BIRTHPLACE (County & State or foreign country) Virginia 12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Unknown 14. MOTHER'S MAIDEN NAME Agnes JACKSON 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) No 16. SOCIAL SECURITY NO. Unknown 17. INFORMANT (Son) SGT Richard Johnson USMC MCS, Quantico, Va. Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Adenocarcinoma, breast with metastasis 170X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a). 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH 2 1/2 yrs.	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)		21. I certify that (X) (this hospital) attended the deceased from June 27 19 61 to July 14 19 61, that (X) (we) last saw the deceased alive on July 14 19 61, and that death occurred at 7P.M. from the causes and on the date stated above. 22a. SIGNATURE 22b. DATE SIGNED 7-15-61 22c. PHYSICIAN'S NAME (Type) U. U. RYSKAMP, JR., LT, MS, USN 22d. ADDRESS U. S. Naval Hospital, Bethesda, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial 23b. DATE THEREOF 19 July 1961 23c. NAME OF CEMETERY OR CREMATORY MT CALVERY 23d. LOCATION (City, town or county) AA COUNTY, MD (State)		24. FUNERAL DIRECTOR'S SIGNATURE R. A. ELLIOTT & Daughter 1129 N. Caroline St. Md. 25a. REC'D BY REGISTRAR DATE JUL 19 61 25b. REGISTRAR'S SIGNATURE Curtis L. Thomas	



TO HOSPITAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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15M 9/60

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

08261
Item 2 Film C293-8/24/61 mb

1. PLACE OF DEATH a. COUNTY Montg		2. USUAL RESIDENCE (Where deceased lived, if Institution; Reside before admission) a. STATE Maryland b. COUNTY Montg	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silverspring Rural. 2 hrs		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silverspring, Germantown	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Marilea Rest Home		d. STREET ADDRESS Rural 14511-Colesville Rd.	
3. NAME OF DECEASED (Type or print) First Minnie Middle Hungerford Last Thomas		4. DATE OF DEATH Month July Day 28 Year 1961	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 17-1878
9. AGE (In years last birthday) 83 yrs.		10. IF UNDER 1 YEAR Months 2 Days 11 Hours Min. 	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Wife		10b. KIND OF BUSINESS OR INDUSTRY H	
11. BIRTHPLACE (Country & State, or foreign country) Brighton N.Y.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Peter Hungerford		14. MOTHER'S MAIDEN NAME Harriet Little	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service)		16. SOCIAL SECURITY NO. 17. INFORMANT Marilea Rest Home Records (As 2)	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Vascular Accident DUE TO Thrombosed coronary arteries Co diseases, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) None			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m. 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from March 5, 1929 to 7-28-1961 , that (I) (we) last saw the deceased alive on 7-28-1961 , and that death occurred 7:30 P.M. from the causes and on the date stated above.			
22a. SIGNATURE John Rogers		22b. DATE SIGNED 7-29-61	
22c. PHYSICIAN'S NAME (Type) John Rogers		22d. ADDRESS 1919 Seminary Rd. Silver Spring, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 7-31-61	
23c. NAME OF CEMETERY OR CREMATORY Forest Oak		23d. LOCATION (City, town or county) (State) Gaithersburg, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Ernest C. Gartner, Gaithersburg, Md.		25a. REC'D BY REGISTRAR DATE AUG 3 '61	
		25b. REGISTRAR'S SIGNATURE Lawrence	



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DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>MARYLAND</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u> c. LENGTH OF STAY IN 1b <u>11 day</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Washington Spring Hosp</u>												2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>1</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Springs</u> d. STREET ADDRESS <u>11901 Lincoln Ave</u>												e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>																																			
3. NAME OF DECEASED (Type or print) <u>William</u>				4. DATE OF DEATH Month <u>July</u> Day <u>14</u> Year <u>1961</u>				5. SEX <u>M</u>				6. COLOR OR RACE <u>White</u>				7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				8. DATE OF BIRTH <u>1-9-77</u>				9. AGE (In years last birthday) <u>73</u> yrs.				IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u>				IF UNDER 24 HRS. Hours <u>0</u> Min. <u>0</u>																											
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>retired</u>												10b. KIND OF BUSINESS OR INDUSTRY <u>Printing Products</u>												11. BIRTHPLACE (County & State, or foreign country) <u>Chicago, Illinois</u>												12. CITIZEN OF WHAT COUNTRY? <u>USA</u>																							
13. FATHER'S NAME <u>John Tobin</u>												14. MOTHER'S MAIDEN NAME <u>Mrs. Anna M. Tobin</u>												15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>no</u>												16. SOCIAL SECURITY NO. <u>322-03-3821</u>												17. INFORMANT <u>Mrs. Anna M. Tobin</u> Address <u>Shady Side, Maryland</u>											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma thyroid gland</u> 153.3 DUE TO <u>with terminal thrombocytopenia</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (c) <u>30 days</u>												INTERVAL BETWEEN ONSET AND DEATH <u>± 6 years</u>																																															
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Cirrhosis of Liver</u>												19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>																																															
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)												20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)																																															
20c. TIME OF INJURY Hour a.m. <u>19</u> p.m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)																																															
21. I certify that (I) (this hospital) attended the deceased from <u>7-12-1961</u> to <u>7-16-1961</u> , that (I) (we) last saw the deceased alive on <u>7-16-1961</u> , and that death occurred at <u>2 P.M.</u> from the causes and on the date stated above.																																																											
22a. SIGNATURE <u>James M. Whitlock M.D.</u>												22b. DATE SIGNED <u>7-16-61</u>																																															
22c. PHYSICIAN'S NAME (Type) <u>James M. Whitlock M.D.</u>												22d. ADDRESS <u>7717 Carrol Ave., Takoma Park, Md.</u>																																															
23a. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>												23b. DATE THEREOF <u>7/19/61</u>												23c. NAME OF CEMETERY OR CREMATORY <u>Gate of Heaven Cemetery</u>												23d. LOCATION (City, town or county) (State) <u>Montgomery Maryland</u>																							
24. FUNERAL DIRECTOR'S SIGNATURE <u>Warner E. Humphrey</u>												25a. REC'D BY REGISTRAR <u>Jul 19 61</u>												25b. REGISTRAR'S SIGNATURE <u>Charles S. Fries</u>																																			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. If the deceased may be retained by the hospital or attending physician, the law requires that the death certificate be executed within 24 hours after death. If the deceased may be retained by the hospital or attending physician, the law requires that the death certificate be executed within 24 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
8270
02263

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural) c. LENGTH OF STAY IN 1b 1 day d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) U. S. Naval Hospital		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Montgomery c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring d. STREET ADDRESS 4966 Allan Road	
3. NAME OF DECEASED (Type or print) Simeon Owen Tolar		4. DATE OF DEATH July 25 19 61	
5. SEX Male		6. COLOR OR RACE Caucasian	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH 10-4-08	
9. AGE (in years last birthday) 52 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
11. BIRTHPLACE (County & State, or foreign country) North Carolina		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Frederick S. Tolar		14. MOTHER'S MAIDEN NAME Caludia Butler	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) Yes		16. SOCIAL SECURITY NO. (W) Molcie R. Tolar Same as # 2 above	
17. INFORMANT (W) Molcie R. Tolar Same as # 2 above		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) Cardiac failure DUE TO myocardial infarction CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last. Coronary atherosclerosis DUE TO Coronary atherosclerosis	
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that XX (this hospital) attended the deceased from July 25 to July 25 , 19 61 that XX (we) last saw the deceased alive on July 25 , 19 61 , and that death occurred 10:40 PM from the causes and on the date stated above			
22a. SIGNATURE Joseph H. Eusterman		22b. DATE SIGNED 26 July 1961	
22c. PHYSICIAN'S NAME (Type) JOSEPH H. EUSTERMAN LT MC USNR		22d. ADDRESS U. S. Naval Hospital, Bethesda, Md.	
23a. BURIAL, CREMATION, 23b. DATE THEREOF REMOVAL (Specify) Burial July 28, 1961		23c. NAME OF CEMETERY OR CREMATORY Arlington National	
23d. LOCATION (City, town or county) (State) Arlington Va.		25a. REC'D BY REGISTRAR 28 7 61	
24 FUNERAL DIRECTOR'S SIGNATURE Robert Humphrey		25b. REGISTRAR'S SIGNATURE Robert Humphrey	

2000

1000

1000

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. If page 4 may be retained by the hospital or attending physician.

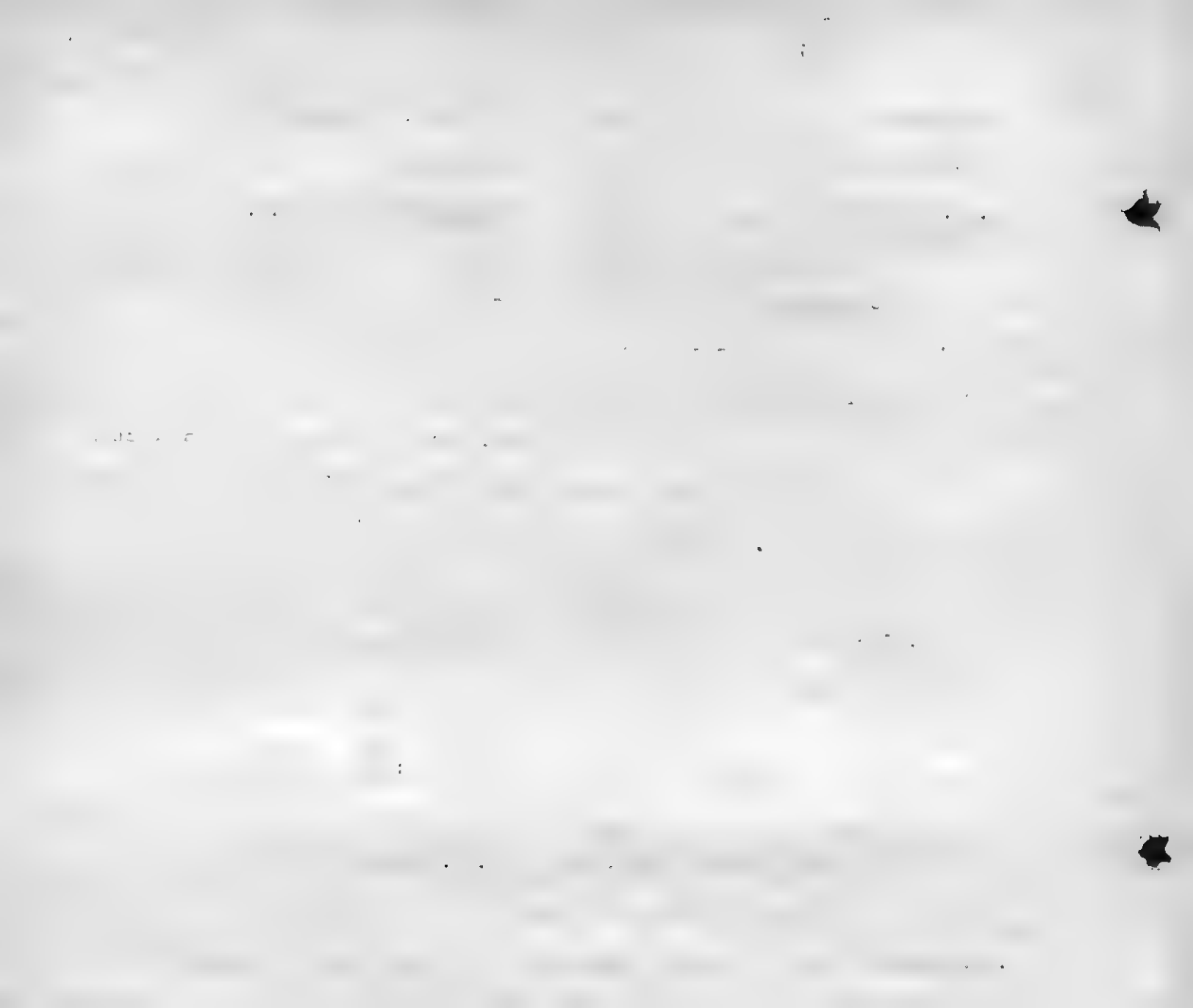
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and complete, filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
8271
CERTIFICATE OF DEATH

08264

1. PLACE OF DEATH a. COUNTY Montgomery		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)		c. LENGTH OF STAY, IN DAYS 34 days		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Dist. of Columbia		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington		d. STREET ADDRESS 5933 Suitland Rd., S.E.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) Raymond Albert TRUITT		F. First		M. Middle		Last		4. DATE OF DEATH July 7 19 61		Month		Day		Year			
5. SEX Male		6. COLOR OR RACE Caucasian		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 3-5-01		9. AGE (In years) (If UNDER 1 YEAR last birthday) 60 yrs.		Months		Days		Hours		Mins.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Cab Driver		10b. KIND OF BUSINESS OR INDUSTRY - - - - -		11. BIRTHPLACE County & State, or foreign country Virginia		12. CITIZEN OF WHAT COUNTRY? USA											
13. FATHER'S NAME Clarence TRUITT		14. MOTHER'S MAIDEN NAME Lena (Unknown)															
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) Yes WWII		16. SOCIAL SECURITY NO.		17. INFORMANT (W) Mrs. Verna B. Truitt, same as #2 above		Address											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 721.1 DUE TO Congestive heart failure Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Calcific aortic stenosis DUE TO (c) Severe Pulmonary Emphysema		INTERVAL BETWEEN ONSET AND DEATH 2 days 30 yrs.															
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>																	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of Item 18)															
20c. TIME OF INJURY Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)		(State)							
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from June 13 1961 to July 7 1961 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on July 7 1961 , and that death occurred at 10:57 PM , from the causes and on the date stated above.																	
22a. SIGNATURE William P. Baker		M.D.		ATTENDING PHYS. <input type="checkbox"/>		MED. DIRECTOR <input type="checkbox"/>		STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED 7-8-61							
22c. PHYSICIAN'S NAME (Type) William P. BAKER, LT, MC, USN		22d. ADDRESS U. S. Naval Hospital, Bethesda, Md.															
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 7-11-61		23c. NAME OF CEMETERY OR CREMATORY Arlington National		23d. LOCATION (City, town or county) Arlington		(State) Virginia									
24. FUNERAL DIRECTOR'S SIGNATURE W. W. Chambers Co., 517 11th St. SE, WashDC		ADDRESS		25a. REC'D BY REGISTRAR JUL 11 '61		25b. REGISTRAR'S SIGNATURE William S. Finner											



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 2 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

8272

8265

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town.) <u>Bethesda</u> c. LENGTH OF STAY IN <u>6 hr.</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Suburban Hospital</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Washington, D.C.</u> b. COUNTY <u>Washington, D.C.</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington, D.C.</u> d. STREET ADDRESS <u>2243-13th St. N.W.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) <u>HATTIE</u> First Middle Last		4. DATE OF DEATH <u>TUCKER</u> <u>July</u> <u>8</u> <u>1961</u> Day Month Year		5. SEX <u>Female</u> 6. COLOR OR RACE <u>Col</u> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Domestic</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>maid</u>		8. DATE OF BIRTH <u>?</u> <u>1905</u> <u>56</u> yrs. 9. AGE (In years last birthday) <u>56</u> yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.		11. BIRTHPLACE (County & State, or foreign country) <u>South Carolina</u> 12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
13. FATHER'S NAME <u>FRANK Foster</u>		14. MOTHER'S MAIDEN NAME <u>Victoria Foster</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> 16. SOCIAL SECURITY NO. <u>ERNEST Foster (brother)</u>
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Increased Intracranial pressure</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Intra cranial Hemorrhage</u> DUE TO (c) <u>Hypertensive Vascular disease</u>		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Obesity</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)		21. I certify that (I) (this hospital) attended the deceased from. <u>7/7</u> <u>1961</u> , to <u>7/8</u> <u>1961</u> , that (I) (we) last saw the deceased alive on <u>7/7</u> <u>1961</u> , and that death occurred at <u>2:45 PM</u> <u>7/8/61</u> from the causes and on the date stated above.
22a. SIGNATURE <u>Theodore B. Ocie</u>		22b. DATE SIGNED <u>7/8/61</u>		22c. PHYSICIAN'S NAME (Type) <u>MD</u>
22d. ADDRESS		23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>7-13-61</u>
23c. NAME OF CEMETERY OR CREMATORY <u>Lincoln</u>		23d. LOCATION (City, town or county) <u>12</u>		23e. REC'D BY REGISTRAR <u>JUL 19 61</u>
24. FUNERAL DIRECTOR'S SIGNATURE <u>W. H. Bacon</u>		25a. REGISTRAR'S SIGNATURE <u>Charles E. Francis</u>		25b. ADDRESS <u>1722 7th St NW</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. Page 2 should be retained by the funeral director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

8273

8266

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> b. CITY OR TOWN (If out of corporate limits, write RURAL and give nearest town) <u>Bethesda</u> c. LENGTH OF STAY in b. <u>1 day</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>SUBURBAN</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>MONTGOMERY</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>GERMANTOWN</u> d. STREET ADDRESS <u>MAJOR DRIVE, Meadowbrook</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>LOUISE</u>		4. DATE OF DEATH Month <u>July</u> Day <u>12</u> Year <u>1961</u>		5. AGE (In years) yrs. <u>7</u> Months <u>11</u> Days <u>11</u> Hours <u>11</u> Min. <u>11</u>	
6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> 8. DATE OF BIRTH <u>JULY 10, 1961</u>		9. AGE (In years) yrs. <u>7</u> Months <u>11</u> Days <u>11</u> Hours <u>11</u> Min. <u>11</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Teacher</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>		11. BIRTHPLACE (County & State or foreign country) <u>MD</u>	
13. FATHER'S NAME <u>JOHN M. VALLANCE</u>		14. MOTHER'S MAIDEN NAME <u>JOAN WICK</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <u>No</u>		16. SOCIAL SECURITY NO <u>None</u>		17. INFORMANT <u>John M. Vallance</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Angiocardiac</u> DUE TO <u>Myocardial infarction</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (c) <u>None</u> DUE TO <u>None</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>None</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>None</u>			
20c. TIME OF INJURY Month, Day, Year <u>19</u> Hour a.m. <u>11</u> p.m. <u>11</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>None</u>	
21. I certify that (I) (this hospital) attended the deceased from <u>7/10/61</u> , 19 <u>61</u> , to <u>7/12/61</u> , 19 <u>61</u> , that (I) (we) last saw the deceased alive on <u>7/12/61</u> , 19 <u>61</u> , and that death occurred at <u>11:00 AM</u> , from the causes and on the date stated above.		22a. SIGNATURE <u>A. J. J. JR.</u>			
22c. PHYSICIAN'S NAME (Type) <u>A. J. J. JR.</u>		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22d. ADDRESS <u>Rockville Medical Center, Rockville, Maryland</u>		22b. DATE SIGNED <u>7/12/61</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>7/13/61</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Gate of Heaven Cemetery</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Lyon Wheeler</u>		25a. REC'D BY REGISTRAR <u>None</u>		25b. REGISTRAR'S SIGNATURE <u>None</u>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
8274
38267
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Bethesda c. LENGTH OF STAY in 1b 46 days d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) The Clinical Center, Bethesda 14, Md.		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE West Virginia b. COUNTY Martinsburg c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Route 4, Box 108 d. STREET ADDRESS 8-2	
3. NAME OF DECEASED (Type or print) Willis Roy Walburn		4. DATE OF DEATH July 28, 1961	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH October 24, 1885
9. AGE (In years last birthday) 75 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Agent		10b. KIND OF BUSINESS OR INDUSTRY Real estate & insurance	
11. BIRTHPLACE (County & State, or foreign country) West Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME George P. Walburn		14. MOTHER'S MAIDEN NAME Harriet Donaldson	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 270-14-2209	
17. INFORMATION The Medical Record		18. CAUSE OF DEATH (Enter only one cause per line, or (a), (b), and (c)) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchopneumonia DUE TO Lymphosarcoma Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)	
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH 3 years	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (this hospital) attended the deceased from June 12 to July 28 , 1961, that (we) last saw the deceased alive on July 28 , 1961, and that death occurred at 8:00PM , from the causes and on the date stated above.			
22a. SIGNATURE Robert H. Levin		22b. DATE SIGNED 7/29/61	
22c. PHYSICIAN'S NAME (Type) Robert H. Levin, M.D.		22d. ADDRESS The Clinical Center, National Institutes of Health, Bethesda 14, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 8-1-1961	
23c. NAME OF CEMETERY OR CREMATORY Rosedale Cemetery		23d. LOCATION (City, town or county) (State) Martinsburg, West Va.	
24. FUNERAL DIRECTOR'S SIGNATURE H. K. Brown		25a. REC'D BY REGISTRAR AUG 1 61	
25b. REGISTRAR'S SIGNATURE Wm. S. Knaus		25c. DATE	

TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

8276
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

08269

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institut an Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sandy Spring		c. LENGTH OF STAY IN 1b life	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INST. Brooke Rd.		d. STREET ADDRESS Brooke Road.,	
3. NAME OF DECEASED (Type or print) William First Middle Last		4. DATE OF DEATH 7 Month 23 Day 1961 Year	
5. SEX male	6. COLOR OR RACE colored	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 1 1888
9. AGE (In years last birthday) 72 yrs		10. IF UNDER 1 YEAR Months Days Hours Min	
11a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		11b. KIND OF BUSINESS OR INDUSTRY Farm	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Hilliary Washington		14. MOTHER'S MAIDEN NAME Mary Thomas	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes If yes, give war or dates of service		16. SOCIAL SECURITY NO. item 2	
17. INFORMANT Mrs. Minerva Washington Address		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 DUE TO Coronary occlusion (recurrent)		INTERVAL BETWEEN ONSET AND DEATH 1hr.	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 7/21/61 to 7/23/61 that (I) (we) lost saw the deceased alive on 7/21/61 , and that death occurred at 5 PM from the causes and on the date stated above			
22a. SIGNATURE C.H. Higdon		22b. DATE SIGNED 7/23/61	
22c. PHYSICIAN'S NAME (Type) C.H. Higdon		22d. ADDRESS Sandy Spring, Md.	
23a. BURIAL CREMATION REMOVAL (Specify) Burial		23b. DATE THEREOF 7/26/61	
23c. NAME OF CEMETERY OR CREMATORY Sandy Spring.,		23d. LOCATION (City, town, or county) (State) Sandy Spring, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Robert L. Snowden ADDRESS Rockville, Md.		25a. REC'D BY REGISTRAR 28 '61	
25b. REGISTRAR'S SIGNATURE Arthur S. House			



TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

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8277
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH
08270

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE WASH DC b. COUNTY ✓	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) TAKOMA PK		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Washington D C	
c. LENGTH OF STAY in 1b 6 days		d. STREET ADDRESS 2816 MILITARY Rd NW	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) WASHINGTON SANATORIUM		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) MINNIE WEINSTEIN		4. DATE OF DEATH Month JULY Day 24 Year 1961	
5. SEX FEMALE	6. COLOR OR RACE wh	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12-25-90
9. AGE (in years last birthday) 70 yrs.		IF UNDER 1 YEAR: Months 70 Days 70 Hours 70 Min. 70	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY At Home	
11. BIRTHPLACE (County & State, or foreign country) Russia		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Louis Lipman		14. MOTHER'S MAIDEN NAME Sarah ?	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		16. SOCIAL SECURITY NO. no	
17. INFIRMANT Hosp RECORDS		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))			
PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) 541-0 DUE TO GI Hemorrhage Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO Duodenal Ulcer (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a.m. 19 Month, Day, Year 7-18 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town, (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 7-18 1961 , to 7-24 1961 , that (I) (we) last saw the deceased alive on JULY 24 1961 , and that death occurred at 7:30 P.M. , from the causes and on the date stated above.			
22a. SIGNATURE Robert Kramer		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) ROBERT KRAMER		22d. ADDRESS 1703 EAST-WEST Highway	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF July 25/61	
23c. NAME OF CEMETERY OR CREMATORY Beth Hamedrosh Hagodol		23d. LOCATION (City, town or county) (State) Rosedale, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE Sol. Levinson & Bros. Inc. 6010 Reist Road		25a. REC'D BY REGISTRAR JUL 27 '61	
25b. REGISTRAR'S SIGNATURE Arthur S. Kramer			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
ISM 9/59

8278

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

08271

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>md.</u> b. COUNTY <u>Mont. Co.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>	
c. LENGTH OF STAY IN 1b <u>8 days 3 hrs 15 min</u>		d. STREET ADDRESS <u>8616 - Lancaster St.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Charles J.</u> Middle <u>Welsh</u> Last <u>Welsh</u>		4. DATE OF DEATH Month <u>July</u> Day <u>20</u> Year <u>1961</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>4/23/97</u>
9. AGE (In years last birthday) <u>64</u> yrs.		10. IF UNDER 1 YEAR: Months <u>6</u> Days <u>14</u> Hours <u>15</u> Min <u>00</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Accountant</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>U.S. Air Force</u>	
11. BIRTHPLACE (State or foreign country) <u>Pennsylvania</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John Wesley Welsh</u>		14. MOTHER'S MAIDEN NAME <u>Bertha Coltrider</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>205-09-4685</u>	
17. INFORMANT <u>Wesley W. Welsh</u>		18. ADDRESS <u>915 - Marshall Ave Rockville, Md</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial infarct</u> DUE TO (b) <u>Coronary thrombosis, left coronary</u> DUE TO (c) <u>Coronary atherosclerosis</u>		INTERVAL BETWEEN ONSET AND DEATH <u>8 days</u> <u>year</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>None</u>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>7/13</u> 19 <u>61</u> , to <u>7/20</u> 19 <u>61</u> , that (I) <u>(we)</u> last saw the deceased alive on <u>7/20</u> 19 <u>61</u> , and that death occurred at <u>5 PM</u> , from the causes and on the date stated above.			
22a. SIGNATURE <u>John H. Tuohy</u>		22b. DATE SIGNED <u>7/21/61</u>	
22c. PHYSICIAN'S NAME (Type) <u>J. H. TUOHY, MD.</u>		22d. ADDRESS <u>7720 WISCONSIN AVE BETHESDA 14, MD.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>7/24/61</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Parklawn</u>		23d. LOCATION (City, town or county) (State) <u>Rockville, Maryland</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Tyson Wheeler Funeral Home - 1331 P. Montg. Ave. Rockville, Maryland</u>		25a. REC'D BY REGISTRAR <u>JUL 24 '61</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles S. Finner</u>			

TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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15M 9/60

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8279
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Wheaton c. LENGTH OF STAY IN b d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Wheaton Nursing Home		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE MARYLAND b. COUNTY D. C. c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington d. STREET ADDRESS 1540 N. Capitol Street		08272	
3. NAME OF DECEASED (Type or print) (Battie) HARRIETT V. white 4. DATE OF DEATH 7 18 1961		5. SEX Female 6. COLOR OR RACE White 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH 2/22/1877 9. AGE (In years If UNDER 1 YEAR If UNDER 24 HRS. last birthday) 84 yrs. 4 Months 26 Days 18 Hours 19 Min.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife 11. BIRTHPLACE (County & State, or foreign country) Washington D. C. USA 12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME George Barker 14. MOTHER'S MAIDEN NAME Harriett Snyder		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No 16. SOCIAL SECURITY NO. None 17. INFORMANT Daughter Address Washington DC Ruth V. Ricker-3710 Jocelyn St. N. W.		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) acute congestive heart failure 420.0 DUE TO arteriosclerotic & hypertensive heart disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO heart disease PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) coronary arteriosclerosis INTERVAL BETWEEN ONSET AND DEATH 4 hrs 10 yrs	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/> 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year 19 Hour a.m. 10 p.m. 19 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21. I certify that (I) (this hospital) attended the deceased from 2/9 1961 , to 2/18 1961 , that (I) (we) last saw the deceased alive on 2/18 1961 , and that death occurred at 11:57 AM , from the causes and on the date stated above. 22a. SIGNATURE H F Kreuzburg 22c. PHYSICIAN'S NAME (Type) H F Kreuzburg 22d. ADDRESS 7852 16th Ave NW Wash DC		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22e. DATE SIGNED 2/18/61			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial 23b. DATE THEREOF 7/21/61 23c. NAME OF CEMETERY OR CREMATORY Glenwood Cemetery 23d. LOCATION (City, town or county) (State) Washington, D. C.		24. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey 25. REC'D BY REGISTRAR JUL 24 '61 25b. REGISTRAR'S SIGNATURE Arthur L. Hines			

TO HOSPITAL: ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

8280

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

08273

1 PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2 USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a STATE Maryland b COUNTY Montgomery	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN 1b 18 Days	
c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chevy Chase 15		d. STREET ADDRESS 4829 Willett Parkway	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center		e. RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First PAUL Middle HOREND Last WILBER		4. DATE OF DEATH Month July Day 3 Year 19 61	
5 SEX Male	6 COLOR OR RACE White	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH 19 December 1935
9 AGE (In years last birthday) 25 yrs		IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Student		10b. KIND OF BUSINESS OR INDUSTRY None	
11 BIRTHPLACE (State or foreign country) New York		12 CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Edward Wilber		14. MOTHER'S MAIDEN NAME Georgia Horend	
15 WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No		16. SOCIAL SECURITY NO (If yes, give war or dates of serv. ca.) 578-48-4631	
17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland			
18 CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) Respiratory Failure 19 3.4 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Neuroblastoma DUE TO (c) 3 Years		INTERVAL BETWEEN ONSET AND DEATH 2 Hours	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21 I certify that (I) (this hospital) attended the deceased from June 15, 19 61 to July 3, 19 61 that (I) (we) last saw the deceased alive on July 3, 19 61 , and that death occurred at 2:30 am from the causes and on the date stated above.			
22a SIGNATURE Richard E. Rieselbach M.D.		22b DATE 7-3-61	
22c. PHYSICIAN'S NAME (Type) RICHARD E. RIESELBACH, M.D.		22d. ADDRESS The Clinical Center, National Institutes of Health, Bethesda 14, Maryland	
23a BURIAL CREMATION, REMOVAL (Specify) Burial		23b DATE THEREOF 7/6/61	
23c NAME OF CEMETERY OR CREMATORY Parklawn Cemetery		23d LOCATION (City, town, or county) (State) Rockville, Maryland	
24 FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey		25a REC'D BY REGISTRAR Bethesda, Maryland	
25b REGISTRAR'S SIGNATURE Arthur S. Kneass		DATE JUL 6 '61	

TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural) c. LENGTH OF STAY IN b 4 hrs d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) U. S. Naval Hospital		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Montgomery c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring d. STREET ADDRESS 3703 Weller Road	
3. NAME OF DECEASED (Type or print) David Smyth WILLETT		4. DATE OF DEATH Month July Day 6 Year 19 61	
5. SEX Male		6. COLOR OR RACE Caucasian	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 7-5-61	
9. AGE (In years last birthday) 3 yrs. 57 Min.		10. IF UNDER 1 YEAR Months 3 Days 57	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) ---		10b. KIND OF BUSINESS OR INDUSTRY ---	
11. BIRTHPLACE (Country & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Leo Vincent WILLETT		14. MOTHER'S MAIDEN NAME Dorothy Frances SULLIVAN	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT (F) Dr. L. V. Willett, same as #2 above		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 773.5 DUE TO Hyaline Membrane Disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO Prematurity (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		INTERVAL BETWEEN ONSET AND DEATH	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER!)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (this hospital) attended the deceased from July 5 19 61 to July 6 19 61 , that (s) (we) last saw the deceased alive on July 6 19 61 , and that death occurred at 2:12AM from the causes and on the date stated above.			
22a. SIGNATURE Fred W. Grello		22b. DATE SIGNED 7-6-61	
22c. PHYSICIAN'S NAME (Type) Fred W. GRELLO, LCDR, MC, USN		22d. ADDRESS U. S. Naval Hospital, Bethesda, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 7-21-61	
23c. NAME OF CEMETERY OR CREMATORY Arlington National		23d. LOCATION (City, town or county) (State) Arlington Virginia	
24. FUNERAL DIRECTOR'S SIGNATURE R. A. Humphrey		25a. REC'D BY REGISTRAR JUL 10 '61	
25b. REGISTRAR'S SIGNATURE Arthur L. Howard			

5. - 6. - 7. - 8. - 9. - 10. - 11. - 12. - 13. - 14. - 15. - 16. - 17. - 18. - 19. - 20. - 21. - 22. - 23. - 24. - 25. - 26. - 27. - 28. - 29. - 30. - 31. - 32. - 33. - 34. - 35. - 36. - 37. - 38. - 39. - 40. - 41. - 42. - 43. - 44. - 45. - 46. - 47. - 48. - 49. - 50. - 51. - 52. - 53. - 54. - 55. - 56. - 57. - 58. - 59. - 60. - 61. - 62. - 63. - 64. - 65. - 66. - 67. - 68. - 69. - 70. - 71. - 72. - 73. - 74. - 75. - 76. - 77. - 78. - 79. - 80. - 81. - 82. - 83. - 84. - 85. - 86. - 87. - 88. - 89. - 90. - 91. - 92. - 93. - 94. - 95. - 96. - 97. - 98. - 99. - 100. - 101. - 102. - 103. - 104. - 105. - 106. - 107. - 108. - 109. - 110. - 111. - 112. - 113. - 114. - 115. - 116. - 117. - 118. - 119. - 120. - 121. - 122. - 123. - 124. - 125. - 126. - 127. - 128. - 129. - 130. - 131. - 132. - 133. - 134. - 135. - 136. - 137. - 138. - 139. - 140. - 141. - 142. - 143. - 144. - 145. - 146. - 147. - 148. - 149. - 150. - 151. - 152. - 153. - 154. - 155. - 156. - 157. - 158. - 159. - 160. - 161. - 162. - 163. - 164. - 165. - 166. - 167. - 168. - 169. - 170. - 171. - 172. - 173. - 174. - 175. - 176. - 177. - 178. - 179. - 180. - 181. - 182. - 183. - 184. - 185. - 186. - 187. - 188. - 189. - 190. - 191. - 192. - 193. - 194. - 195. - 196. - 197. - 198. - 199. - 200. - 201. - 202. - 203. - 204. - 205. - 206. - 207. - 208. - 209. - 210. - 211. - 212. - 213. - 214. - 215. - 216. - 217. - 218. - 219. - 220. - 221. - 222. - 223. - 224. - 225. - 226. - 227. - 228. - 229. - 230. - 231. - 232. - 233. - 234. - 235. - 236. - 237. - 238. - 239. - 240. - 241. - 242. - 243. - 244. - 245. - 246. - 247. - 248. - 249. - 250. - 251. - 252. - 253. - 254. - 255. - 256. - 257. - 258. - 259. - 260. - 261. - 262. - 263. - 264. - 265. - 266. - 267. - 268. - 269. - 270. - 271. - 272. - 273. - 274. - 275. - 276. - 277. - 278. - 279. - 280. - 281. - 282. - 283. - 284. - 285. - 286. - 287. - 288. - 289. - 290. - 291. - 292. - 293. - 294. - 295. - 296. - 297. - 298. - 299. - 300. - 301. - 302. - 303. - 304. - 305. - 306. - 307. - 308. - 309. - 310. - 311. - 312. - 313. - 314. - 315. - 316. - 317. - 318. - 319. - 320. - 321. - 322. - 323. - 324. - 325. - 326. - 327. - 328. - 329. - 330. - 331. - 332. - 333. - 334. - 335. - 336. - 337. - 338. - 339. - 340. - 341. - 342. - 343. - 344. - 345. - 346. - 347. - 348. - 349. - 350. - 351. - 352. - 353. - 354. - 355. - 356. - 357. - 358. - 359. - 360. - 361. - 362. - 363. - 364. - 365. - 366. - 367. - 368. - 369. - 370. - 371. - 372. - 373. - 374. - 375. - 376. - 377. - 378. - 379. - 380. - 381. - 382. - 383. - 384. - 385. - 386. - 387. - 388. - 389. - 390. - 391. - 392. - 393. - 394. - 395. - 396. - 397. - 398. - 399. - 400. - 401. - 402. - 403. - 404. - 405. - 406. - 407. - 408. - 409. - 410. - 411. - 412. - 413. - 414. - 415. - 416. - 417. - 418. - 419. - 420. - 421. - 422. - 423. - 424. - 425. - 426. - 427. - 428. - 429. - 430. - 431. - 432. - 433. - 434. - 435. - 436. - 437. - 438. - 439. - 440. - 441. - 442. - 443. - 444. - 445. - 446. - 447. - 448. - 449. - 450. - 451. - 452. - 453. - 454. - 455. - 456. - 457. - 458. - 459. - 460. - 461. - 462. - 463. - 464. - 465. - 466. - 467. - 468. - 469. - 470. - 471. - 472. - 473. - 474. - 475. - 476. - 477. - 478. - 479. - 480. - 481. - 482. - 483. - 484. - 485. - 486. - 487. - 488. - 489. - 490. - 491. - 492. - 493. - 494. - 495. - 496. - 497. - 498. - 499. - 500. - 501. - 502. - 503. - 504. - 505. - 506. - 507. - 508. - 509. - 510. - 511. - 512. - 513. - 514. - 515. - 516. - 517. - 518. - 519. - 520. - 521. - 522. - 523. - 524. - 525. - 526. - 527. - 528. - 529. - 530. - 531. - 532. - 533. - 534. - 535. - 536. - 537. - 538. - 539. - 540. - 541. - 542. - 543. - 544. - 545. - 546. - 547. - 548. - 549. - 550. - 551. - 552. - 553. - 554. - 555. - 556. - 557. - 558. - 559. - 560. - 561. - 562. - 563. - 564. - 565. - 566. - 567. - 568. - 569. - 570. - 571. - 572. - 573. - 574. - 575. - 576. - 577. - 578. - 579. - 580. - 581. - 582. - 583. - 584. - 585. - 586. - 587. - 588. - 589. - 590. - 591. - 592. - 593. - 594. - 595. - 596. - 597. - 598. - 599. - 600. - 601. - 602. - 603. - 604. - 605. - 606. - 607. - 608. - 609. - 610. - 611. - 612. - 613. - 614. - 615. - 616. - 617. - 618. - 619. - 620. - 621. - 622. - 623. - 624. - 625. - 626. - 627. - 628. - 629. - 630. - 631. - 632. - 633. - 634. - 635. - 636. - 637. - 638. - 639. - 640. - 641. - 642. - 643. - 644. - 645. - 646. - 647. - 648. - 649. - 650. - 651. - 652. - 653. - 654. - 655. - 656. - 657. - 658. - 659. - 660. - 661. - 662. - 663. - 664. - 665. - 666. - 667. - 668. - 669. - 670. - 671. - 672. - 673. - 674. - 675. - 676. - 677. - 678. - 679. - 680. - 681. - 682. - 683. - 684. - 685. - 686. - 687. - 688. - 689. - 690. - 691. - 692. - 693. - 694. - 695. - 696. - 697. - 698. - 699. - 700. - 701. - 702. - 703. -

1942

$\frac{1}{\sqrt{\pi}} \int_{-\infty}^{\infty} f(x) e^{-x^2} dx = \frac{1}{\sqrt{\pi}}$

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

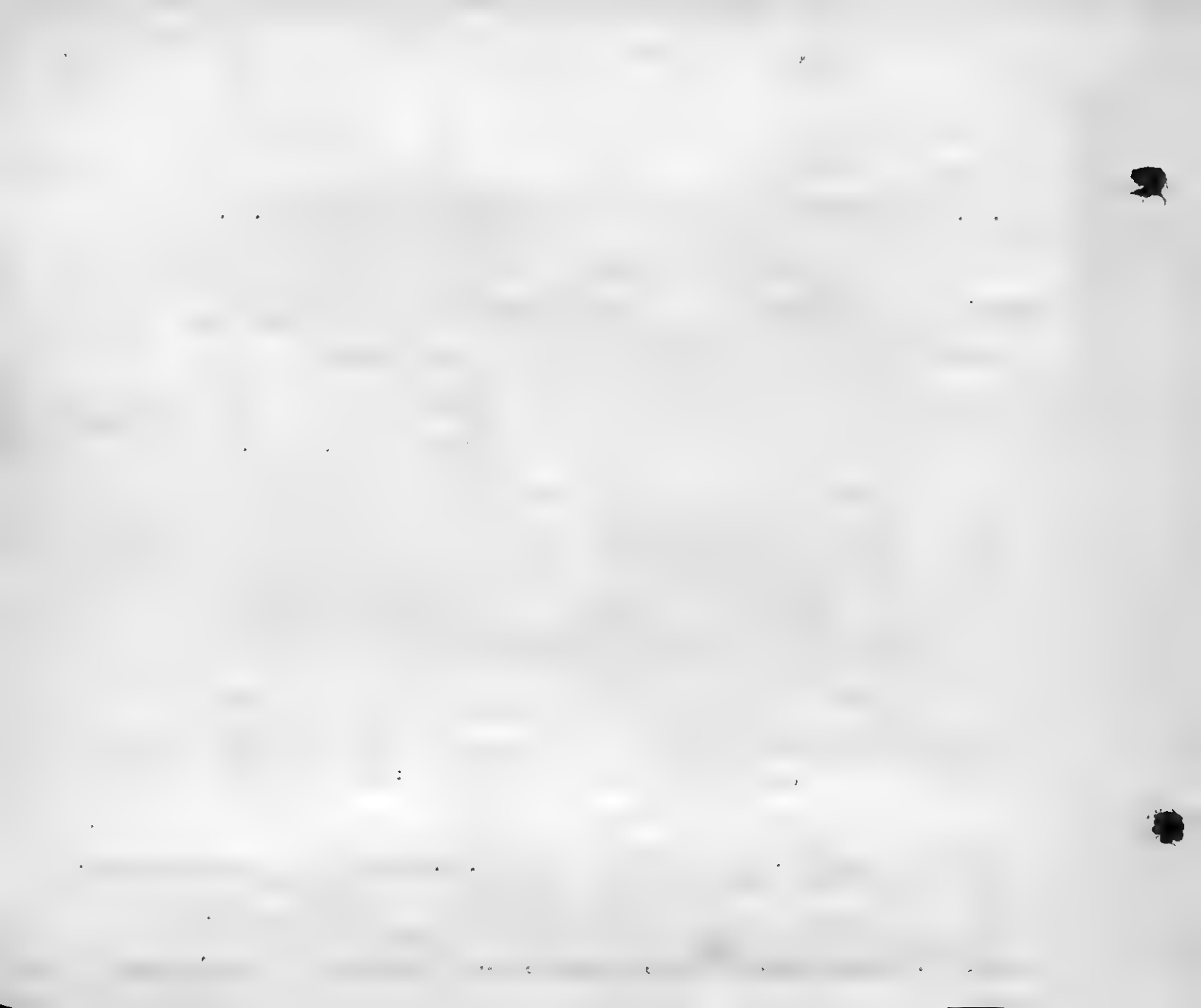
VR A15 (4)
15M 9/60

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

8282

08275

| | | | |
|--|--|---|--|
| 1. PLACE OF DEATH
a. COUNTY
Montgomery
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Bethesda (Rural)
c. LENGTH OF STAY IN 1b
MARYLAND
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
U. S. Naval Hospital, | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE
District of Columbia
b. COUNTY
Washington
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Washington
d. STREET ADDRESS
3814 Yuma Street, N. W. | |
| 3. NAME OF DECEASED
(Type or print)
Alice Marie Wilson | | 4. DATE OF DEATH
July 25 19 61 | |
| 5 SEX
Female | | 6. COLOR OR RACE
Caucasian | |
| 7. MARRIED
<input type="checkbox"/> NEVER MARRIED
<input checked="" type="checkbox"/> WIDOWED
<input type="checkbox"/> DIVORCED | | 8. DATE OF BIRTH
12-19-84 | |
| 9. AGE (In years last birthday)
76 yrs. | | 10. IF UNDER 1 YEAR
Months 25 Days 19 Hours 61 Min. | |
| 11. BIRTHPLACE (County & State, or foreign country)
California | | 12. CITIZEN OF WHAT COUNTRY?
USA | |
| 13. FATHER'S NAME
Joseph Baer | | 14. MOTHER'S MAIDEN NAME
Hermine Taubles | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown) (If yes give year or dates of service)
No | | 16. SOCIAL SECURITY NO.
Richard H. Wilson, 428 S. Second St. | |
| 17. INFORMANT
Warrington, Fla | | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Myocardial infarct, or
DUE TO Arterio sclerotic heart disease
Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. (b) 20 years
(c) 24 hours | |
| 19. WAS AUTOPSY PERFORMED?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
Severe diarrhea 8 week duration | |
| 21. I certify that (this hospital) attended the deceased from July 19 19 61 to July 25 19 61 , that (we) last saw the deceased alive on July 25 19 61 , and that death occurred at 4:12 PM from the causes and on the date stated above. | | 22. SIGNATURE
Vernon N. Houk
22c. PHYSICIAN'S NAME (Type)
Vernon N. Houk, LCDR MC USN | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23b. DATE THEREOF
July 31, 1961 | |
| 23c. NAME OF CEMETERY OR CREMATORY
Arlington National | | 23d. LOCATION (City, town or county) (State)
Fort Meyer, Va. | |
| 24. FUNERAL DIRECTOR'S SIGNATURE
Robert A. Pumphrey
ADDRESS
Robert A. Pumphrey Funeral Home, Bethesda, Md. | | 25. REC'D BY REGISTRAR
July 28 '61 | |
| 26. REGISTRAR'S SIGNATURE
Arthur S. Hanna | | 27. REGISTRAR'S SIGNATURE
Arthur S. Hanna | |



8283

CERTIFICATE OF DEATH

Reg. Dist. No. 02276

| | | | | | | | |
|--|--|--|--|--|--|--|---|
| 1. PLACE OF DEATH
a. COUNTY <u>MONTGOMERY</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution. Residence before admission)
a. STATE <u>MARYLAND</u> b. COUNTY <u>PRINCE GEO.</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SILVER SPRING MD</u>
<u>4511 Polesville Rd</u> | | | | c. LENGTH OF STAY IN TB | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street/address) OR INSTITUTION
<u>MARLEA NURSING HOME</u> | | | | d. STREET ADDRESS
<u>4741 PORTER AVE.</u> | | | |
| 3. NAME OF DECEASED (Type or print)
First <u>EVA</u> Middle <u>TRENE</u> Last <u>WILSON</u> | | | | 4. DATE OF DEATH
Month <u>JULY</u> Day <u>7</u> Year <u>1961</u> | | | |
| 5. SEX
<u>FEMALE</u> | | 6. COLOR OR RACE
<u>white</u> | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
<u>4-6-83</u> | |
| 9. AGE (In years last birthday)
<u>78</u> yrs | | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>HOUSEWIFE</u> | | 11. BIRTHPLACE (State or foreign country)
<u>WAVY VA.</u> | | 12. CITIZEN OF WHAT COUNTRY?
<u>U.S.A.</u> | |
| 13. FATHER'S NAME
<u>EDWARD R. MARBLE</u> | | | | 14. MOTHER'S MAIDEN NAME
<u>UNKNOWN</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no or unknown)
<u>NO</u> | | 16. SOCIAL SECURITY NO
<u>NONE</u> | | 17. INFORMANT
<u>GARY M. WILSON SAMEERS # 2</u> | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>cerebral Infarction</u>
<u>-332-X</u> DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>cerebral Thrombosis</u>
DUE TO (c) <u>cerebral Arteriosclerosis</u> | | | | | | | INTERVAL BETWEEN ONSET AND DEATH
<u>48 hrs</u>
<u>48 hrs</u>
<u>Indefinite</u> |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)
<u>Diets</u> | | | | | | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) | | | |
| 20c. TIME OF INJURY
Hour <u>19</u> o. m. <u>19</u> p. m. | | | | 20d. INJURY OCCURRED
While of work <input type="checkbox"/> Not while of work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| | | | | 20f. (City or town) | | (County) (State) | |
| 21. I certify that I attended the deceased from <u>7/1/61</u> 19 <u>61</u> , to <u>7/7/61</u> 19 <u>61</u> , that I last saw the deceased alive on <u>7/6/61</u> 19 <u>61</u> , and that death occurred at <u>1 P.</u> M, from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE
<u>Stephen N. Jones</u> | | | | M.D. <u>Rockville, Md</u> | | DATE SIGNED
<u>7/7/61</u> | |
| PHYSICIAN'S NAME (Type)
<u>STEPHEN N. JONES</u> | | | | | | | |
| 22a. BURIAL CREMATION, REMOVAL (Specify) | | 22b. DATE THEREOF | | 22c. NAME OF CEMETERY OR CREMATORY | | 22d. LOCATION (City, town or county) (State) | |
| <u>Burial</u> | | <u>7/10/61</u> | | <u>Wash. Natl.</u> | | <u>Southeast Md.</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
<u>Wm. Chamberlaine</u> | | | | ADDRESS
<u>517 11th St. S.E.</u> | | 24a. REC'D BY REGISTRAR
DATE <u>JUL 10 '61</u> | |
| | | | | | | 24b. REGISTRAR'S SIGNATURE
<u>Arthur S. Thomas</u> | |

TO HOSPITALS ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

2285

02273

| | | | |
|---|--|---|--|
| 1. PLACE OF BIRTH
a. COUNTY
Montgomery
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Bethesda
c. LENGTH OF STAY IN Ib
22 days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
The Clinical Center, Bethesda 14, Md. | | 2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission)
a. STATE
Virginia
b. COUNTY
Fairfax
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Falls Church
d. STREET ADDRESS
6488 Glen Carlyn Road
e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED
(Type or print)
First
Violet
Middle
Rose
Last
Wood | | 4. DATE OF DEATH
Month
July
Day
4,
Year
1961 | |
| 5. SEX
Female | | 6. COLOR OR RACE
White | |
| 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
September 4, 1924 | |
| 9. AGE (In years last birthday)
36 yrs | | 10. IF UNDER 1 YEAR
Months
Days
Hours
Min | |
| 11a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Housewife | | 11b. KIND OF BUSINESS OR INDUSTRY
None | |
| 11c. BIRTHPLACE (State or foreign country)
Virginia | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 13. FATHER'S NAME
Ellis Branham | | 14. MOTHER'S MAIDEN NAME
Mary Allen | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown) (If yes, give war or dates of service)
No | | 16. SOCIAL SECURITY NO
233-30-1632 | |
| 17. INFORMANT
The Medical Record | | Address
The Clinical Center, Bethesda 14, Maryland | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Hodgkin's Disease
201X DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Lung Abscess - atypical acid-fast bacillus infection | | | |
| 19. WAS AUTOPSY PERFORMED?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | |
| 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. p.m. 19 | | | |
| 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | | |
| 20f. (City or town) (County) (State) | | | |
| 21. I certify that (I) (this hospital) attended the deceased from June 12, 1961 to July 4, 1961 , that (I) (we) last saw the deceased alive on July 4, 1961 , and that death occurred at 1:55 PM , from the causes and on the date stated above. | | | |
| 22a. SIGNATURE
Geo. H. Porter, III
M.D.
22b. PHYSICIAN'S NAME (Type)
George H. Porter, III M.D. | | | |
| 22c. ATTENDING PHYS <input type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/> 7-4-61
22d. ADDRESS
The Clinical Center, National Institute of Health, Bethesda 14, Maryland | | | |
| 22e. DATE SIGNED | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | | |
| 23b. DATE THEREOF
7/7/61 | | | |
| 23c. NAME OF CEMETERY OR CREMATORY
Wallace Mem. Cemetery | | | |
| 23d. LOCATION (City, town, or county) (State)
Clintonsville, W. Virginia | | | |
| 24. FUNERAL DIRECTOR'S SIGNATURE
Robert A. Pumphrey | | | |
| ADDRESS
Bethesda, Maryland | | | |
| 25a. REC'D BY REGISTRAR
DATE JUL 6 '61 | | | |
| 25b. REGISTRAR'S SIGNATURE
Arthur S. Thomas | | | |

100 x 100 x 100

8286

CERTIFICATE OF DEATH

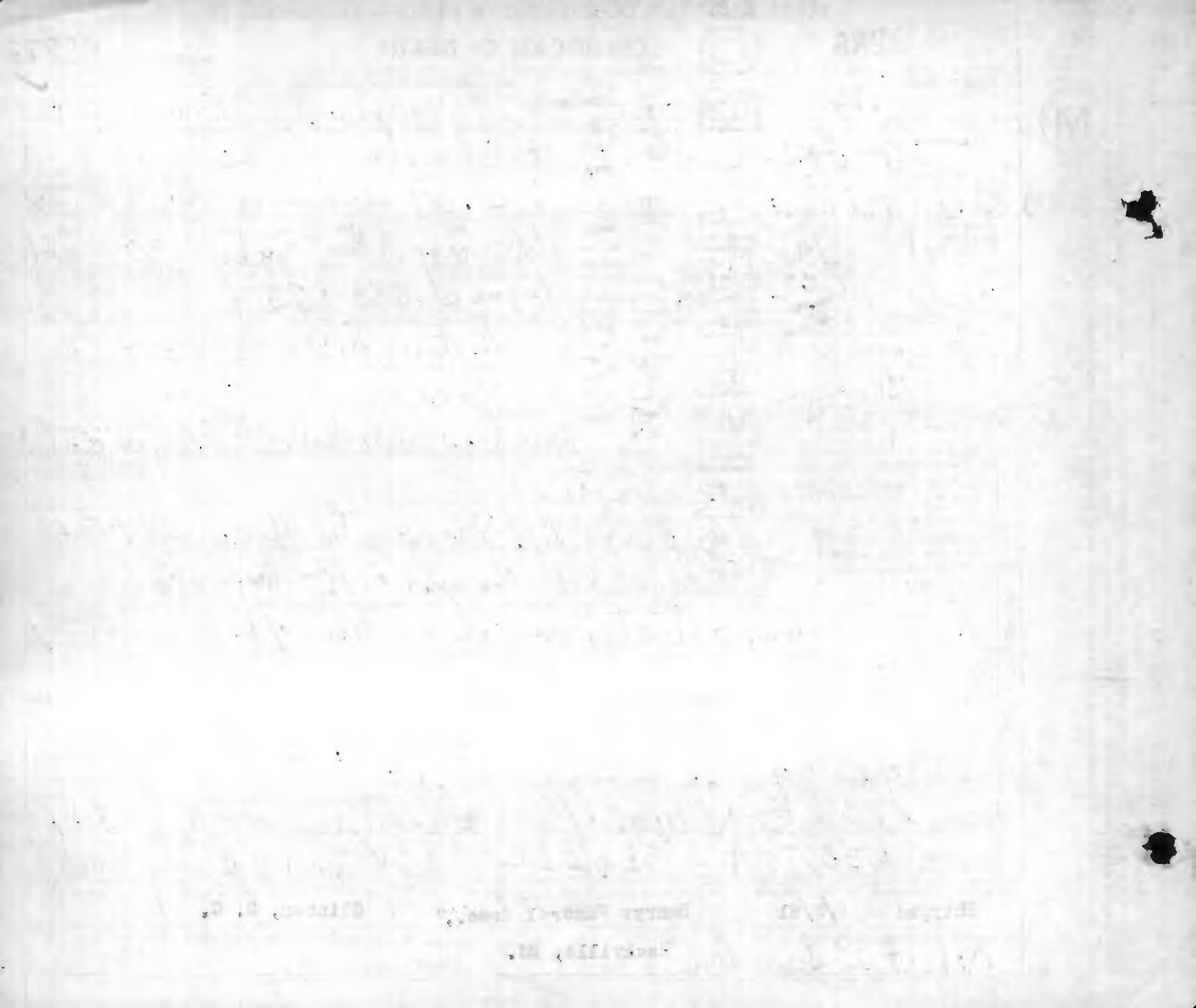
Reg. Dist. No.

08273

| | | | |
|---|---------------------------------|--|---|
| 1. PLACE OF DEATH
a. COUNTY <i>Montgomery</i> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission)
a. STATE <i>Maryland</i> b. COUNTY <i>Prince Georges</i> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Norbeck</i> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Chapel Oaks</i> | |
| c. LENGTH OF STAY IN 1b <i>Jan 1958</i> | | d. STREET ADDRESS <i>5707 Addison Rd.</i> | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Bradford Nursing Home</i> | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First Middle Last <i>Jack Young</i> | | 4. DATE OF DEATH Month Day Year <i>July 30 1961</i> | |
| 5. SEX <i>Male</i> | 6. COLOR OR RACE <i>C</i> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <i>June 15, 1888</i> |
| 9. AGE (In years last birthday) <i>73</i> yrs | | 10. IF UNDER 1 YEAR: Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Farmer</i> | | 10b. KIND OF BUSINESS OR INDUSTRY <i>Clinton, S.C.</i> | |
| 11. BIRTHPLACE (State or foreign country) <i>U.S.A.</i> | | 12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i> | |
| 13. FATHER'S NAME <i>George Gary</i> | | 14. MOTHER'S MAIDEN NAME <i>Kissie Owens</i> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. <i>INFORMANT</i> | |
| 17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <i>Peritonitis</i>
561.5 DUE TO (b) <i>Ruptured Left Incarcerated Hernia</i>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <i>Incarcerated Hernia Left inoperable</i> | | INTERVAL BETWEEN ONSET AND DEATH <i>7.18.61</i> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Ductal Arteritis & Osteomyelitis of knee of hip</i> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i> | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from <i>1958</i> to <i>July 30, 1961</i> , that I last saw the deceased alive on <i>July 29, 1961</i> , and that death occurred at <i>6:00 A.M.</i> from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE <i>Robert L. Suowden</i> M.D. | | DATE SIGNED <i>8.1.61</i> | |
| PHYSICIAN'S NAME (Type) <i>WEBSTER SEWELL</i> | | ADDRESS (Street, city or town, state) <i>Norbeck, Norwood Rd, Silver Spring Md</i> | |
| 22a. BURIAL, CREMATION, REBURY (Specify) <i>Shipped</i> | 22b. DATE THEREOF <i>8/3/61</i> | 22c. NAME OF CEMETERY OR CREMATORY <i>Henrys Funeral Home.</i> | 22d. LOCATION (City, town, or county) (State) <i>Clinton, S. C.</i> |
| 23. FUNERAL DIRECTOR'S SIGNATURE <i>Robert L. Suowden</i> ADDRESS <i>Rockville, Md.</i> | | 24a. REC'D BY REGISTRAR <i>AUG 7 '61</i> | 24b. REGISTRAR'S SIGNATURE <i>Arthur S. Knaus</i> |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOUSEHOLD OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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8287
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

08280

| | | | |
|---|-------------------------------|---|---------------------------------------|
| 1. PLACE OF DEATH
a. COUNTY MONTGOMERY MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE MARYLAND b. COUNTY MONTGOMERY | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) OLNEY | | c. LENGTH OF STAY IN 1b 5 DAYS | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MONTGOMERY GENERAL HOSPITAL | | d. STREET ADDRESS MOXLEY ROAD | |
| 3. NAME OF DECEASED (Type or print)
First ASBURY Middle ZEIGLER Last | | 4. DATE OF DEATH
Month JULY Day 19 Year 1961 | |
| 5. SEX MALE | 6. COLOR OR RACE NEGRO | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH July 10, 1911 |
| 9. AGE (In years last birthday) 50 yrs. | | IF UNDER 1 YEAR IF UNDER 24 HRS.
Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) LABORER | | 10b. KIND OF BUSINESS OR INDUSTRY Farm | |
| 11. BIRTHPLACE (State or foreign country) MARYLAND | | 12. CITIZEN OF WHAT COUNTRY? U. S. A. | |
| 13. FATHER'S NAME SAMUEL ZEIGLER | | 14. MOTHER'S MAIDEN NAME LAIGE FRY | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. 212-14-3413 | |
| 17. INFORMANT Joseph Zeigler, Damascus, Md. | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cerebral hemorrhage
DUE TO Hypertensive Cardiovascular disease
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Diabetes Mellitus
DUE TO (c) | | INTERVAL BETWEEN ONSET AND DEATH 24 hrs | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour o. m. p. m. 19 | | 20d. INJURY OCCURRED While <input type="checkbox"/> at work <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from 7/14 19 61 to 7/19 19 61 that (I) (we) last saw the deceased alive on 7/19 19 61 and that death occurred at 1400 PM from the causes and on the date stated above. | | | |
| 22a. SIGNATURE John P. Martin | | 22b. DATE SIGNED | |
| 22c. PHYSICIAN'S NAME (Type) JOHN P. MARTIN, M. D. | | 22d. ADDRESS SANDY SPRING, MARYLAND | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b. DATE THEREOF 7/22/61 | |
| 23c. NAME OF CEMETERY OR CREMATORY Friendship Meth. | | 23d. LOCATION (City, town, or county) (State) Damascus, Md. | |
| 24. FUNERAL DIRECTOR'S SIGNATURE Oliver L. Molsan | | 24a. ADDRESS Damascus, Md. | |
| 25a. REC'D BY REGISTRAR JUL 24 '61 | | 25b. REGISTRAR'S SIGNATURE Arthur S. Fries | |

